



GEAUGA COUNTY BOARD OF COMMISSIONERS

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Backflow Prevention Device Test and Maintenance Report

Customer: _____ Type of Device: _____
 Account Number: _____ Manufacturer: _____
 Service Address: _____ Size: _____
 Location of Backflow: _____ Serial #: _____

Check one of the following: Initial _____ Annual _____ Replacement _____

OSHA confined space entry requirements apply on ALL testing and repair of backflow prevention devices within a vault.

Owner's Certification:

This device has been in constant use at this location in a manner approved by the Department of Water Resources. During the entire prescribed interval between test periods this device was not by-passed, made inoperative or removed without authorization. All defects found during the operation period or during the operation period or during tests of the device were corrected without delay.

Owner/Agent Signature: _____ Title: _____

Date: _____ Phone: _____

	Check Valve 1	Check Valve 2	Differential Pressure Relief Valve	Pressure Vacuum Breaker & SVB	
				Air Inlet	Check Valve
Initial Test	1. Leaked _____ RP _____ PSID 2. Closed Tight _____	1. Leaked _____ 2. Closed Tight _____	1. Opened at _____ PSID Reduced Pressure 2. Did not open _____	1. Opened at _____ PSID 2. Did not open _____	1. Closed Tight _____ PSID 2. Leaked _____
R E P A I R S	<input type="checkbox"/> Cleaned: <input type="checkbox"/> Replaced: <input type="checkbox"/> Disk <input type="checkbox"/> Spring <input type="checkbox"/> Guide <input type="checkbox"/> Pin Retainer <input type="checkbox"/> Hinge Pin <input type="checkbox"/> Seat <input type="checkbox"/> Diaphragm <input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> Cleaned: <input type="checkbox"/> Replaced: <input type="checkbox"/> Disk <input type="checkbox"/> Spring <input type="checkbox"/> Guide <input type="checkbox"/> Pin Retainer <input type="checkbox"/> Hinge Pin <input type="checkbox"/> Seat <input type="checkbox"/> Diaphragm <input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> Cleaned: <input type="checkbox"/> Replaced: <input type="checkbox"/> Disk Upper <input type="checkbox"/> Disk Lower <input type="checkbox"/> Spring <input type="checkbox"/> Diaphragm, Large <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Diaphragm, Small <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Spacer Lower <input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> Cleaned: <input type="checkbox"/> Replaced:	<input type="checkbox"/> Cleaned: <input type="checkbox"/> Replaced:
Final Test	RP _____ PSID Closed Tight _____	Closed Tight _____	Opened at _____ PSID Reduced Pressure	Opened at _____ PSID	Closed Tight _____ PSID

Detector Check Meter Reading _____ Gallons or _____ Cubic Feet

TEST CERTIFICATION: I certify that the foregoing test report is correct.

Company: _____ Tester: _____

Address: _____ Certification: _____

Phone: _____ Date: _____

Updated 07/22 KAM

Office Use Only: Verification Signature: _____ Date: _____