

TOWN OF LELAND UTILITIES DEPARTMENT Backflow Prevention Assembly Test and Maintenance Report

Name of Owner _____

Street Address: _____

Location of Assembly: _____

Meter Number: _____

Type _____ Manufacturer: _____ Model: _____ Size: _____ Serial No: _____

Tester: _____ Certification No: _____ Date: _____ Time: _____

Type of Service: **New Test** **Recertification Test** **Line Pressure:** _____

Test Kit: _____ **Serial No:** _____ **Calibration Date:** _____

RELIEF VALVE	NO.1 CHECK VALVE	NO.2 CHECK VALVE	PRESSURE VACUUM BREAKER
Opened AT: _____ PSID BUFFER: _____ PSID DID NOT OPEN: <input type="checkbox"/>	<input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT DIFF.PRESSURE ACROSS CHECK VALVE: _____ PSID	<input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT DIFF.PRESSURE ACROSS CHECK VALVE: _____ PSID	AIR INLET OPENED AT: _____ PSID DID NOT OPEN CHECK VALVE: <input type="checkbox"/> LEAKED <input type="checkbox"/> HELD AT: _____ PSID
<input type="checkbox"/> CLEANED <input type="checkbox"/> REPLACED	<input type="checkbox"/> CLEANED <input type="checkbox"/> REPLACED	<input type="checkbox"/> CLEANED <input type="checkbox"/> REPLACED	<input type="checkbox"/> CLEANED <input type="checkbox"/> REPLACED
Opened AT: _____ PSID BUFFER: _____ PSID	<input type="checkbox"/> CLOSED TIGHT _____ PSID	<input type="checkbox"/> CLOSED TIGHT _____ PSID	AIR INLET _____ PSID CHECK VALVE _____ PSID
SHUT OFF VALVE # 1 <input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT		SHUT OFF VALVE # 2 <input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT	

This Assembly: ___ PASSED ___ FAILED

I hereby certify that this data is accurate and reflects the proper operation and maintenance of the assembly,

SIGNATURE OF TESTER: _____

***ALL REPAIRS MUST BE MADE WITHIN 10 BUSINESS DAYS.**

*** TEST AND MAINTENANCE REPORT MUST BE SUBMITTED WITHIN 15 DAYS.**

**102 Town Hall Drive Leland NC, 28451
Telephone 910-371-6506.**