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: ☐	☐ LEAKED ☐ CLOSED TIGHT DIFF.PRESSURE ACROSS CHECK VALVE: _____PSID	☐ LEAKED ☐ CLOSED TIGHT DIFF.PRESSURE ACROSS CHECK VALVE:_____PSID	AIR INLET OPENED AT: _____ PSID DID NOT OPEN ☐ CHECK VALVE: LEAKED ☐ HELD AT: _____ PSID
☐ CLEANED ☐ REPLACED	☐ CLEANED ☐ REPLACED	☐ CLEANED ☐ REPLACED	☐ CLEANED ☐ REPLACED
Opened AT: _____ PSID BUFFER:_____ PSID	☐ CLOSED TIGHT _____ PSID	☐ CLOSED TIGHT _____ PSID	AIR INLET _____ PSID CHECK VALVE _____ PSID
SHUT OFF VALVE # 1 ☐ LEAKED ☐ CLOSED TIGHT		SHUT OFF VALVE # 2 ☐ LEAKED ☐ 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.**

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