



**BACKFLOW PREVENTION ASSEMBLY TEST AND MAINTENANCE REPORT \*PWS ID# 1700101**

**ILLEGIBLE OR INCOMPLETE TEST REPORTS WILL NOT BE ACCEPTED**

NAME OF PROPERTY: \_\_\_\_\_

PROPERTY ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_, STATE: \_\_\_\_\_, ZIP: \_\_\_\_\_, KEY MAP #: \_\_\_\_\_, PHONE #: (\_\_\_\_) \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ CONTACT PERSON: \_\_\_\_\_

Send This Signed & Dated Original Report to: **NEW CANEY MUD; P. O. BOX 1799, NEW CANEY, TX 77357**

THE BACKFLOW PREVENTION ASSEMBLY DETAILED HEREON HAS BEEN TESTED AND MAINTAINED AS REQUIRED BY TCEQ-Chapter 290, RULES AND REGULATIONS FOR PUBLIC WATER SYSTEMS, CITY'S UNIFORM PLUMBING CODE, AND IS CERTIFIED TO COMPLY WITH THE REQUIREMENTS. THE FOLLOWING FORM MUST BE COMPLETED FOR EACH ASSEMBLY TESTED. A SIGNED AND DATED ORIGINAL MUST BE SUBMITTED TO THE PUBLIC WATER SUPPLIER FOR RECORDKEEPING \*PURPOSES:

TYPE OF ASSEMBLY

NEW \_\_\_\_\_ EXISTING \_\_\_\_\_ REPLACED \_\_\_\_\_ (OLD SERIAL # REPLACED)  
 REDUCED PRESSURE PRINCIPLE (RP)     REDUCED PRESSURE PRINCIPLE-DETECTOR (RPD)     PRESSURE VACUUM BREAKER (PVB)  
 DOUBLE CHECK VALVE (DCV)     DOUBLE CHECK VALVE-DETECTOR (DCD)     SPILL-RESISTANT PRESSURE VACUUM BREAKER (SVB)  
 MANUFACTURER \_\_\_\_\_ MODEL # \_\_\_\_\_ SIZE \_\_\_\_\_ SERIAL NUMBER \_\_\_\_\_

SERVING/LOCATION: \_\_\_\_\_ DATE INSTALLED: \_\_\_\_\_

Is the assembly installed in accordance with manufacturer recommendations and/or City's Uniform Plumbing Code? \_\_\_\_\_

	REDUCED PRESSURE PRINCIPLE ASSEMBLY			PRESSURE VACUUM BREAKER & SVB	
	DOUBLE CHECK VALVE ASSEMBLY		RELIEF VALVE	AIR INLET	CHECK VALVE
	CHECK VALVE #1	CHECK VALVE #2			
<b>INITIAL TEST</b>	HELD At _____ PSID CLOSED TIGHT <input type="checkbox"/> LEAKED <input type="checkbox"/>	HELD At _____ PSID CLOSED TIGHT <input type="checkbox"/> LEAKED <input type="checkbox"/>	OPENED AT _____ PSID DID NOT OPEN <input type="checkbox"/>	OPENED AT _____ PSID DID NOT OPEN <input type="checkbox"/>	HELD AT _____ PSID LEAKED <input type="checkbox"/>
<b>REPAIRS** MATERIAL USED</b>					
<b>FINAL TEST</b>	HELD At _____ PSID CLOSED TIGHT <input type="checkbox"/>	HELD At _____ PSID CLOSED TIGHT <input type="checkbox"/>	OPENED AT _____ PSID	OPENED AT _____ PSID	HELD AT _____ PSID

TEST GAUGE USED: MAKE/MODEL: \_\_\_\_\_ S/N: \_\_\_\_\_ CALIBRATION DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Tested annually)

REMARKS: \_\_\_\_\_

THE ABOVE TEST IS CERTIFIED TO BE TRUE AT THE TIME OF TESTING  
 Backflow Test Status  Pass  Fail

CT's FIRM NAME: \_\_\_\_\_

TESTER NAME: \_\_\_\_\_

FIRM ADDRESS: \_\_\_\_\_

CITY TESTER NO.: \_\_\_\_\_

FIRM PHONE #: \_\_\_\_\_

TEST DATE: \_\_\_\_\_

TESTER SIGNATURE: \_\_\_\_\_

\*TEST REPORTS MUST BE KEPT FOR AT LEAST THREE YEARS.  
 TESTING IS REQUIRED UPON INSTALLATION, REPAIR, OR RELOCATION AND ANNUALLY THEREAFTER.  
 \*\* USE ONLY MANUFACTURERS' REPLACEMENT PARTS.  
 ALL TEST REPORTS MUST BE SUBMITTED WITHIN 15 DAYS OF THE TEST & FAILED DEVICES MUST BE REPAIRED WITHIN 10 DAYS OF INITIAL TEST.