Town of Monument
Backflow Prevention Assemblies
Test Data

Owner: _____

Service Address: _____

Mailing Address: _____

Contact Person: _____ Title: _____

Phone: _____

Assembly or Method Type: _____ Location on Property: _____

Make of Device: _____ Model No.: _____ Serial No.: _____ Size: _____

Line Pressure: _____ Date Installed: _____ Last Inspection: _____

INSTALLATION TYPE: Domestic_____ Fire_____ Irrigation _____ Isolation _____

PRESSURE VACUUM BREAKER	
AIR INLET	CHECK VALVE
OPENED _____ PSID	FIRST TEST _____ PSID WITH FLOW _____ PSID
REPAIRS OR COMMENTS:	

REDUCED PRESSURE ZONE		
FIRST CHECK	SECOND CHECK	RELIEF VALVE
DIRECTION OF FLOW _____ PSID	DIRECTION OF FLOW _____ PSID HELD TIGHT___LEAKED___	_____ PSID
REPAIRS OF COMMENTS:		

DUAL CHECK (SINGLE FAMILY RESIDENTIAL ONLY)
CLEANED CHECKS _____ REPLACED CHECKS
COMMENTS:

DOUBLE CHECK	
FIRST CHECK	SECOND CHECK
DIRECTION OF FLOW _____ PSID	DIRECTION OF FLOW _____ PSID
REPAIRS OR COMMENTS:	

PASSED: _____+ **FAILED: _____** **TEST DATE: _____**

If device failed, who was person notified? _____

CERTIFIED CROSS-CONNECTION CONTROL TECHNICIAN (PLEASE PRINT): _____

CERTIFICATION EXPIRATION DATE : _____ CERT. TESTER #: _____

CERTIFICATION AGENCY: _____

CERTIFICATION AGENCY ADDRESS: _____

CERTIFICATION AGENCY PHONE #: _____

The Above is Certified to be True by (Signature): _____

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