



**CITY OF ALLEN COMMUNITY SERVICES DEPARTMENT  
BACKFLOW PREVENTION ASSEMBLY TEST REPORT  
PWS I.D. 0430025  
305 Century Parkway Allen , Texas 75013  
214-509-4530 \* Fax: 972-390-8418**

**\*\*\*This form must be submitted to Building Inspections Dept prior to scheduling Final Inspection.**

**MAKE SURE ALL LINES ARE FILLED IN OR THE FORM IS NOT COMPLETE**

**Name of Business** \_\_\_\_\_ ☐ Residential ☐ Commercial

**Address of Assembly:** \_\_\_\_\_ ☐ Domestic ☐ Irrigation ☐ Fireline

**Mailing Address:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_

☐ **New Installation or replacement**

☐ **Annual Test**

The backflow prevention assembly detailed below has been tested and maintained as required by TCEQ (Formerly TNRCC) regulations and is certified to be operating within acceptable parameters

**TYPE OF ASSEMBLY**

- |  |  |
|--|--|
| 1) <input type="checkbox"/> Reduced Pressure Principle | <input type="checkbox"/> Reduced Pressure Principle-Detector     |
| 2) <input type="checkbox"/> Double Check Valve         | <input type="checkbox"/> Double Check-Detector                   |
| 3) <input type="checkbox"/> Pressure Vacuum Breaker    | <input type="checkbox"/> Spill Resistant Pressure Vacuum Breaker |

Manufacturer: \_\_\_\_\_

Size: \_\_\_\_\_

Model Number: \_\_\_\_\_

Serial Number: \_\_\_\_\_

Located At: \_\_\_\_\_

Is the assembly installed in accordance with manufacturer recommendations and/or local codes? \_\_\_\_\_

	Reduced Pressure Principle Assembly			Pressure Vacuum Breaker	
	Double Check Valve Assembly		Relief Valve	Air Inlet	Check Valve
	1 <sup>st</sup> check	2 <sup>nd</sup> check			
Initial Test	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"/>
Repairs and Materials Used					
Test after Repair	Held at ____ psid	Held at ____psid Closed Tight <input type="checkbox"/>	Opened at ____psid	Opened at ____psid	Held at ____psid

Remarks: \_\_\_\_\_

The above is certified to be true at the time of testing. Tester signature: \_\_\_\_\_

Test gauge used: Make/Model \_\_\_\_\_ SN: \_\_\_\_\_ Calibration Date: \_\_\_\_\_

Firm Name: \_\_\_\_\_

Certified Tester (print): \_\_\_\_\_

Firm Address: \_\_\_\_\_

Cert. Tester No. \_\_\_\_\_ Exp. Date \_\_\_\_\_

Firm Phone #: \_\_\_\_\_

Test Date \_\_\_\_\_ Time: \_\_\_\_\_

- **TEST RECORDS MUST BE KEPT FOR AT LEAST THREE YEARS.**
- **USE ONLY MANUFACTURER'S REPLACEMENT PARTS.**
- **IF REPLACEMENT DEVICE IS NEEDED PLEASE NOTE OLD DEVICE NUMBER ON FORM.**