

Send completed form to:
Consolidated Mutual Water
12700 West 27th Ave.
Lakewood, Colorado 80215
Phone No: (303) 238-0451
Fax No: (303) 237-5560

Company Information

Device Serial No _____
 Test Date/Time _____
 Tester Certification _____
 Device Test Result Pass Fail

Backflow Prevention Device Test & Maintenance Report

Keep Records for 3 Years:

(Please Print)

All Fields Must Be Completed

Account	Owners Name: _____ Owners Phone: _____ Owners Address: _____ City: _____ ST: _____ Zip: _____ Service Name: _____ Phone: _____ Address: _____ City: _____ ST: _____ Zip: _____					
Device	Make: _____ Model: _____ Size: _____ Type: <input type="checkbox"/> RPZ <input type="checkbox"/> DC <input type="checkbox"/> PVB <input type="checkbox"/> AVB <input type="checkbox"/> Air Gap Date Installed: _____ Location on property: _____ <input type="checkbox"/> New <u>Orientation</u> <u>Use</u> <u>Protection</u> <input type="checkbox"/> Existing <input type="checkbox"/> Vertical Up <input type="checkbox"/> Domestic <input type="checkbox"/> Containment Previous Device Serial No _____ <input type="checkbox"/> Vertical Down <input type="checkbox"/> Fire <input type="checkbox"/> Isolation <input type="checkbox"/> Horizontal <input type="checkbox"/> Irrigation					
Testing & Maintenance		Initial Test Results		Repairs/Comments	Re-Test Results	
		Tightness	Differential		Tightness	Differential
	Check Valve #1 (RPZ, DC, PVB)	<input type="checkbox"/> Leak <input type="checkbox"/> Tight			<input type="checkbox"/> Leak <input type="checkbox"/> Tight	
	Check Valve #2 (RPZ, DC)	<input type="checkbox"/> Leak <input type="checkbox"/> Tight			<input type="checkbox"/> Leak <input type="checkbox"/> Tight	
	Relief Valve (RPZ)					
	Buffer (RPZ)					
	Air Inlet (PVB)					
	Shutoff Valve #1	<input type="checkbox"/> Leak <input type="checkbox"/> Tight				
	Shutoff Valve #2	<input type="checkbox"/> Leak <input type="checkbox"/> Tight				
	Comments: _____ _____ _____ Test Procedure: _____					
Notification	Alarm Company/Fire Department Notified: _____ Person Notified: _____ Notified By: _____ Turn Off Date/Time: _____ Turn On Date/Time: _____					
Test Kit	Test Kit Make: _____ Model: _____ Serial No: _____ Last Calibration Date: _____					
Tester	Tester Name: _____ Certificate Expiration Date: _____ Tester certifies that this assembly has been tested with the above listed procedure and verifies that isolation valves were returned to pre-test orientation. Signature: _____ Phone: _____					