HARRIS COUNTY FRESH WATER SUPPLY DISTRICT 61

OPERATOR for MUD 248

DRINKING WATER OPERATIONS/CROSS CONNECTION CONTROL
BACKFLOW PREVENTION ASSEMBLY TEST AND MAINTENANCE REPORT

ILLEGIBLE OR INCOMPLETE TEST REPORTS WILL NOT BE ACCEPTED

NAME OFPROPERTY: ____________________

PROPERTY ADDRESS: ____________________

CITY:__________, **STATE:**______, **ZIP:**________, **KEY MAP #:**____-___, **PHONE #:** (___)____-________

MAILING ADDRESS:____________________**CONTACT PERSON:** ____________

Send This Original Report to: Harris County Fresh Water Supply District 61 – P.O. Box 325 Cypress, TX 77429

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.

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			
INITIAL TEST	D.C. CLOSED TIGHT ☐ RP________PSI LEAKED ☐	CLOSED TIGHT ☐ ________PSI LEAKED ☐	OPENED AT ________PSI DID NOT OPEN ☐	OPENED AT ________PSI DID NOT OPEN ☐	HELD AT ________PSI LEAKED ☐
REPAIRS** MATERIAL USED					
FINAL TEST	D.C. CLOSED TIGHT ☐ RP________PSI	CLOSEDTIGHT ☐ ________PSI	OPENED AT ________PSI	OPENED AT ________PSI	HELD AT ________PSI

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.:**____________

____________ **TEST DATE:** ____________

FIRM PHONE #:____________ ***WITNESS***____________

***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.**