

FINDLAY TOWNSHIP MUNICIPAL AUTHORITY

90 Strouss Road, P.O. Box 409, Clinton, P.A. 15026

Phone: 724-695-3108 Fax: 724-695-3405

TEST AND MAINTENANCE REPORT FOR BACKFLOW PREVENTION

Name:	Account No.:
Contact:	Telephone No.:
Service Address:	
Device Type:	Serial No.:
Size:	Manufacturer:
Model:	Degree of Hazard:
Meter Association:	Location:
Test Due Date:	

Instructions for Certified Testers: All applicable information must be typed or clearly printed. Failure to complete this form will result in rejection of the test form and possible result in water service termination. **Please attach a copy of your certification.**

- Reduced Pressure Principle Backflow Prevention Assembly (RPZ)*
 Double Check Valve Backflow Prevention Assembly (DC)

Static Line Pressure PSID	Check Valve #1	Check Valve #2	Differential Pressure Relief Valve
Initial Test of Device Date:	___ Leaked ___ Closed ___ PSID (RPZ)	___ Leaked ___ Closed Tight	___ Opened @ ___ PSID ___ Did not open
Maintenance of Device Date: _____	___ Cleaned ___ Repaired Material Used: _____	___ Cleaned ___ Repaired Material Used: _____	___ Cleaned ___ Repaired Material Used: _____
Changed or New Device Installed (must be tested on line)	<u>DC</u> Size _____ Model _____ Serial _____ Mfg. _____		<u>RPZ</u> Size _____ Model _____ Serial _____ Mfg. _____
Final Test of Device Date:	___ Closed Tight ___ PSID(RPZ)	___ Closed Tight	___ Opened @ ___ PSID

REMARKS: _____

Certification of Tester: I hereby certify the above date to be correct and that the above backflow prevention assembly is in proper operation condition.

Tester (signature): _____ Test Date: _____
 Tester (print): _____ Cert. No.: _____
 Company Name: _____ Phone: _____
 Test Kit Used: _____ Test Kit Calibration Date: _____

*Please return this form and a copy of your Certification to FTMA.
 Email: kyle@ftmawatersewer.com*