

RETURN THIS TEST FORM TO:
SILVER CREEK WATER CORPORATION

Mail: 8104 County Line Road, Sellersburg, IN 47172 Email: scott@silvercreekwater.org Web: www.silvercreekwater.org Phone: 812-246-2889 Fax: 812-246-6503

Customer and Device Information		
1. Customer name		2. Customer Account No.:
3. Customer address (number and street, city, state, and ZIP code)		4. Premise No.
5. Location of device (and address if different from customer)		6. Is the device a new assembly? <input type="checkbox"/> Yes <input type="checkbox"/> No Replacing serial number:
7. Type of service <input type="checkbox"/> Domestic <input type="checkbox"/> Fire <input type="checkbox"/> Irrigation		8. Type of assembly <input type="checkbox"/> RP <input type="checkbox"/> DC <input type="checkbox"/> PVB <input type="checkbox"/> SVB <input type="checkbox"/> Air Gap <input type="checkbox"/> AVB
9. Type of protection <input type="checkbox"/> Isolation <input type="checkbox"/> Containment		10. Serial number of device
11. Size of device	12. Manufacturer of device	13. Model number of device
14. Additional information (optional)		

14. Test Measurements					
	RP				
	DC				PVB/SVB
	Check Valve #1	Check Valve #2			Pressure Differential Relief Valve
Initial Date (mm/dd/yy): _____ Time: _____ <input type="checkbox"/> PASS <input type="checkbox"/> FAIL	Held at _____ PSID <input type="checkbox"/> Closed Tight <input type="checkbox"/> Leaked	Held at _____ PSID <input type="checkbox"/> Closed Tight <input type="checkbox"/> Leaked	Opened at _____ PSID <input type="checkbox"/> Did Not Open	Opened at _____ PSID <input type="checkbox"/> Did Not Open Check Valve Held _____ PSID	
Final Date (mm/dd/yy): _____ Time: _____ <input type="checkbox"/> PASS <input type="checkbox"/> FAIL	Held at _____ PSID <input type="checkbox"/> Closed Tight <input type="checkbox"/> Leaked	Held at _____ PSID <input type="checkbox"/> Closed Tight <input type="checkbox"/> Leaked	Opened at _____ PSID <input type="checkbox"/> Did Not Open	Opened at _____ PSID <input type="checkbox"/> Did Not Open Check Valve Held _____ PSID	

AIR GAP Measured vertical inches above overflow rim : _____ Supply size diameter: _____	AVB Opened fully? <input type="checkbox"/> Yes <input type="checkbox"/> No
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15. Comments

Tester Information			
Initial Tester	16. Name and e-mail address of tester		17. Company name of tester (if applicable)
	18. Telephone number	19. Signature and registration number of tester	
	20. Testing equipment serial number	21. Testing equipment calibration date (mm/dd/yy)	
Final Tester	22. Name and e-mail address of tester		23. Company name of tester (if applicable)
	24. Telephone number	25. Signature and registration number of tester	
	26. Testing equipment serial number	27. Testing equipment calibration date (mm/dd/yy)	

By signing this backflow test report and checking this box, I hereby certify that I am familiar with the information contained in this form and that to the best of my knowledge and belief, such information is true, complete and accurate at the time of the test.