SULLIVAN'S ISLAND TESTING AND MAINTENANCE REPORT FOR BACKFLOW PREVENTION ASSEMBLIES

☐ **PASSED** **THIS FORM MUST BE FILLED OUT COMPLETELY** **FAILED** ☐

DATE _____ ACCOUNT NAME/BUSINESS NAME _____
SERVICE ADDRESS _____
ACCOUNT NO _____ METER NO. _____
ASSEMBLY NAME _____ MODEL NO. _____ SIZE _____ SERIAL NO. _____
ASSEMBLY LOCATION (SPECIFY) _____
BACKFLOW PREVENTION ASSEMBLY TYPE: PVB _____ DCVA _____ RP _____ AIR-GAP _____

DEFINE HAZARD (beauty shop, restaurant, irrigation, car lot, medical facility, etc.) _____

	Check Valve No. 1	**Check Valve No. 2**	**Relief Valve or Air-Inlet Valve**	**#1 Shutoff Valve**	**#2 Shutoff Valve**
Test Before Repairs	(Mark One) Leaked _____ Closed Tight _____	(Mark One) Leaked _____ Closed Tight _____	Opened At Differential Pressure _____ PSI	#1 Gate or Ball (Circle One)	#2 Gate or Ball (Circle One)
	Differential Pressure _____ PSI	Differential Pressure _____ PSI		(Mark One) Leaked _____ Closed Tight _____	(Mark One) Leaked _____ Closed Tight _____
Repairs and New Materials					
Test After Repairs	(Mark One) Leaked _____ Closed Tight _____	(Mark One) Leaked _____ Closed Tight _____	Opened At Differential Pressure _____PSI	#1 Gate or Ball (Circle One)	#2 Gate or Ball (Circle One)
	Differential Pressure _____PSI	Differential Pressure _____PSI		(Mark One) Leaked _____ Closed Tight _____	(Mark One) Leaked_____ Closed Tight_____

TESTER AFFIDAVIT

Test must be performed by a general, limited, or inspector tester duly certified by the South Carolina Department of Health and Environmental Control. Repair materials used must be original manufacturer's parts. I have provided a copy of this report to the customer and am responsible for sending the original passing or failing report to Sullivan's Island Water Department within seven (7) days of testing the assembly. I hereby certify that the above testing and/or repair was performed by myself, _____ and the information is correct.

(signature)

CHECK CATEGORY: GENERAL _____ LIMITED _____ INSPECTOR TESTER _____ DHEC CERT. NO. _____
COMPANY NAME _____ COMPANY TELEPHONE _____

IMPORTANT: COMMENTS AND CONDITION OF ASSEMBLY: (HORIZONTAL, VERTICAL, TC MISSING, NO CLEARANCE, MISSING BOX, PRESSURE GAUGE ON TC, ETC.) _____

TESTED BY **(PRINT):** _____ DATE: _____ TIME: _____
METHOD OF TESTING: _____ TEST KIT USED: _____
REPAIRED/RETESTED BY: _____ DATE: _____ TIME: _____
INSTALLED BY: _____ DATE: _____ TIME: _____
☐ IS THIS A NEW ASSEMBLY? IF YES, CHECK BLOCK AND PROVIDE MAKE, MODEL, SIZE AND SERIAL No. OF ASSEMBLY REMOVED: _____