



THE CORPORATION OF THE CITY OF ST. CATHARINES

www.stcatharines.ca

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Backflow Prevention Device Test Report
Reduced Pressure Principle Assembly

Transportation and Environmental Services
Operations Division
E-Mail Completed Form to backflow@stcatharines.ca

Facility Address:

Occupant (Business Name): Phone number:

Company Contact Name: E-Mail:

Property Owner/Contact: Phone number:

Mailing Address: E-Mail:

Qualified Tester (Name and Company): Phone number:

OWWA Certification #: Calibration Due Date of Test Equipment:

Make and Model of Test Equipment: Test Equipment Serial #:

Backflow Device Information

Device location in facility:			Type: <input type="checkbox"/> DCVA <input type="checkbox"/> PVB
Make:	Model:	Serial #:	Size:
Install date (DD/MM/YYYY):		Protection Type: <input type="checkbox"/> premise isolation <input type="checkbox"/> source/internal	
Test type: <input type="checkbox"/> Initial <input type="checkbox"/> Annual		Date of test (DD/MM/YYYY):	

RP Assembly Test

Differential Pressure Relief Valve <input type="checkbox"/> Failed to open <input type="checkbox"/> Opened at _____	Check Valve No. 1 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight Pressure Differential Across Check Valve: _____	Check Valve No. 2 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight Pressure Differential Across Check Valve: _____
Shut Off Valve 2 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight	Buffer = _____ (the Pressure Differential Across Check Valve No. 1 minus the Pressure at which Relief Valve Opened)	
Test Result <input type="checkbox"/> Passed <input type="checkbox"/> Failed Line pressure at time of test: _____		
If the device fails for any reason, complete this section and note repair below Reason for failure:		

RP Assembly Repair

Differential Pressure Relief Valve <input type="checkbox"/> Cleaned Replaced <input type="checkbox"/> Spring <input type="checkbox"/> Diaphragm <input type="checkbox"/> Seat <input type="checkbox"/> Other:	Check Valve No. 1 <input type="checkbox"/> Cleaned Replaced <input type="checkbox"/> Spring <input type="checkbox"/> Diaphragm <input type="checkbox"/> Seat <input type="checkbox"/> Other:	Check Valve No. 2 <input type="checkbox"/> Cleaned Replaced <input type="checkbox"/> Spring <input type="checkbox"/> Diaphragm <input type="checkbox"/> Seat <input type="checkbox"/> Other:	Shut Off Valve 2 Replaced <input type="checkbox"/> Disc <input type="checkbox"/> Seat <input type="checkbox"/> Other:
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RP Assembly Re-test

Differential Pressure Relief Valve <input type="checkbox"/> Failed to open <input type="checkbox"/> Opened at _____	Check Valve No. 1 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight Pressure Differential Across Check Valve: _____	Check Valve No. 2 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight Pressure Differential Across Check Valve: _____
Shut Off Valve 2 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight	Buffer = _____ (the Pressure Differential Across Check Valve No. 1 minus the Pressure at which Relief Valve Opened)	
Test Result <input type="checkbox"/> Passed <input type="checkbox"/> Failed Line pressure at time of test: _____		

I certify I have tested the above device in accordance with City of St. Catharines By-law No. 2005-200 amended by By-law No. 2010-107 and the CSA Std. B64.10/B64.10.1

Tester Signature:

Date (DD/MM/YYYY):