



**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:			
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**

<b>Differential Pressure Relief Valve</b> <input type="checkbox"/> Failed to open <input type="checkbox"/> Opened at _____  <b>Shut Off Valve 2</b> <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight	<b>Check Valve No. 1</b> <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight Pressure Differential Across Check Valve: _____	<b>Check Valve No. 2</b> <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight Pressure Differential Across Check Valve: _____
	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**

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

<b>Differential Pressure Relief Valve</b> <input type="checkbox"/> Failed to open <input type="checkbox"/> Opened at _____  <b>Shut Off Valve 2</b> <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight	<b>Check Valve No. 1</b> <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight Pressure Differential Across Check Valve: _____	<b>Check Valve No. 2</b> <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight Pressure Differential Across Check Valve: _____
	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):