



THE CORPORATION OF THE CITY OF ST. CATHARINES

www.stcatharines.ca

PO Box 3012, 50 Church Street
St. Catharines, ON L2R 7C2
Tel: 905.688.5600
TTY: 905.688.4TTY (4889)

**Backflow Prevention Device Test Report
Double Check Valve or Pressure Vacuum Breaker**

Municipal Works *Operations Division*
E-mail 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:		Source/Purpose:	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):	

DCVA/PVB Assembly Test

Double Check Valve Assembly		Pressure Vacuum Breaker	
Check Valve No. 1 - with flow	Check Valve No. 2 - with flow	Check Valve	Air Inlet Valve
<input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight	<input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight	<input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight	<input type="checkbox"/> Failed to open <input type="checkbox"/> Opened at _____
Pressure Differential Across Check Valve No. 1: _____	Pressure Differential Across Check Valve No. 2: _____	Pressure Differential Across Check Valve: _____	
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:			

DCVA/PVB Assembly Repair

DCVA - Check Valve No. 1	DCVA - Check Valve No. 2	Pressure Vacuum Breaker
<input type="checkbox"/> Cleaned Replaced <input type="checkbox"/> Spring <input type="checkbox"/> Diaphragm <input type="checkbox"/> Seat <input type="checkbox"/> Other:	<input type="checkbox"/> Cleaned Replaced <input type="checkbox"/> Spring <input type="checkbox"/> Diaphragm <input type="checkbox"/> Seat <input type="checkbox"/> Other:	<input type="checkbox"/> Cleaned Replaced <input type="checkbox"/> Vent Disc <input type="checkbox"/> Poppet <input type="checkbox"/> Vent Spring Other:

DCVA/PVB Assembly Re-test

Double Check Valve Assembly		Pressure Vacuum Breaker	
Check Valve No. 1 - with flow	Check Valve No. 2 - with flow	Check Valve	Air Inlet Valve
<input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight	<input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight	<input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight	<input type="checkbox"/> Failed to open <input type="checkbox"/> Opened at _____
Pressure Differential Across Check Valve No. 1: _____	Pressure Differential Across Check Valve No. 2: _____	Pressure Differential Across Check Valve: _____	
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):