

MOON TOWNSHIP MUNICIPAL AUTHORITY
1700 Beaver Grade Road, Suite 200, Moon Township, PA 15108

TEST AND MAINTENANCE REPORT FORM FOR BACKFLOW PREVENTION ASSEMBLIES

Name or Business:	Account No.:
Contact:	Telephone No:
Service address:	
Device Type:	Serial No.:
Size:	Manufacturer:
Model:	Degree of Hazard
Meter use- Commercial <input type="checkbox"/> Irrigation <input type="checkbox"/> Fire <input type="checkbox"/>	Location of meter
Next Test Due Date	

INSTRUCTIONS FOR CERTIFIED TESTERS: All applicable information must be typed or clearly printed. Failure to complete this form accurately will result in rejection of the test form and possible result in water service termination. *Please attach a wallet size copy of your certification.*

Reduced Pressure Principle Backflow Prevention Assembly (RPZ)

Double Check Valve Backflow Prevention Assembly (DC)

Static Line Pressure ____ PSID	Check Valve #1	Check Valve #2	Differential Pressure Relief Valve
Initial Test of Device Date: ___/___/___	<input type="checkbox"/> Leaked <input type="checkbox"/> Closed ____ PSID (RPZ)	<input type="checkbox"/> Leaked <input type="checkbox"/> Closed tight	<input type="checkbox"/> Opened @ ____ PSID <input type="checkbox"/> Did not open
Maintenance of Devices Date: ___/___/___	<input type="checkbox"/> Cleaned <input type="checkbox"/> Repaired Material used _____	<input type="checkbox"/> Cleaned <input type="checkbox"/> Repaired Material used _____	<input type="checkbox"/> Cleaned <input type="checkbox"/> Repaired Material used _____
Changed or New Device Installed (must be tested on line)	<input type="checkbox"/> DC Size _____ Model _____ Serial _____ Mfg. _____		<input type="checkbox"/> RPZ Size _____ Model _____ Serial _____ Mfg. _____
Final Test of Device Date: ___/___/___	<input type="checkbox"/> Closed tight ____ PSID(RPZ)	<input type="checkbox"/> Closed tight	Opened at _____ PSID

REMARKS: _____

CERTIFICATION OF TESTER: I hereby certify the above data to be correct and that the above backflow prevention assembly is in proper operation condition.

Tester (signature): _____

Test Date: _____

Tester (print): _____

Cert. No.: _____

Company Name: _____

Phone: _____

Test Kit Used: _____

Test Kit Gauge Calibration Date _____

PLEASE RETURN TO: Ryan Gubala, Inspector
Phone: 412.264.4300 x 117
Email: rgubala@moontma.com

PLEASE INCLUDE THE ACCOUNT NUMBER
Fax: 412.262.9482