City of Golden
CCC Program
1445 10th Street
Golden CO 80401
Ph: 303-384-8178 Fax: 303-384-8161
backflow@cityofgolden.net

Assembly Serial # _____
Test Date/Time _____
Gauge Serial # _____
▶District Required Info _____
Tester Certification # _____
Date Certification Expires _____

Assembly Test Results ☐ **Pass** ☐ **Fail**

Backflow Prevention Assembly Test & Maintenance Report

Test #: _____

(Please Print)

Account

Water District/ Authority: _____ Account: _____ Contact Person: _____
Facility Name: _____ Contact Phone # : _____
Service Address: _____
Mailing Address: _____

OMC

Owner ☐ Manager ☐ Contractor ☐ Other: _____ Contact Person: _____
Company Name/ Title: _____ Contact Phone # : _____
Mailing Address: _____

Assembly

Make: _____ Model: _____ Size: _____
Type: ☐ **RPZ** ☐ **DC** ☐ **PVB** ☐ **SVB** ☐ **Air Gap** ☐ **AVB** ☐ **Other** _____
Date Installed: _____ Location on Property: _____
(Only if Applicable - Include Previous Serial#)
☐ Replacement Assembly
☐ New Installation
☐ Stolen
Previous Assembly Serial # _____

Orientation (*Inlet:* / *Outlet:*)
☐ ↑ Vertical Up ↑ ☐
☐ ↓ Vertical Down ↓ ☐
☐ → Horizontal → ☐

Service
☐ Domestic
☐ Fire
☐ Irrigation
☐ Other _____

Protection
☐ **Containment**
☐ **Isolation**
☐ **Containment By Isolation**

Testing & Maintenance

Line PSI: _____

	Initial Test Results		Repaired: Ck#1☐ Ck#2☐ RV☐	Cleaned: Ck#1☐ Ck#2☐ RV☐	Re-Test Results	
	Tightness	Differential			Tightness	Differential
Check Valve #1 (Ck#1: RPZ,DC,PVB,SVB)	☐ Leak ☐ Tight		*Ck#1* disc☐ spring☐ seat☐ other:		☐ Leak ☐ Tight	
Check Valve #2 (Ck#2: RPZ, DC)	☐ Leak ☐ Tight		*Ck#2* disc☐ spring☐ seat☐ other:		☐ Leak ☐ Tight	
Relief Valve (RV: RPZ)			*RV* diaphram ☐ seat☐ other:			
Buffer (RPZ)			Repaired: Air Inlet ☐	Cleaned: Air Inlet☐		
Air Inlet (Air Inlet: PVB,SVB)			*Air Inlet* poppet ☐ bonnet☐ other:			
Shutoff Valve #1	☐ Leak ☐ Tight		*SOV #1* Open Upon Arrival:☐ Open Upon Departure: ☐		Backpressure Exists? Yes ☐ No ☐	
Shutoff Valve #2	☐ Leak ☐ Tight		*SOV #2* Open Upon Arrival ☐ Open Upon Departure: ☐		Cause:	
Assembly Concerns: (only if applicable) Incorrect Installation? ☐ ABPA ☐ ASSE ☐ Incorrect Use ? ☐	Test Procedure:		Comments:			
Turn Off Date: __/__/__ Turn Off Time: __:__	Turn On Date: __/__/__ Turn On Time: __:__					

Notice

Alarm Company/Fire Department Notified: _____ DFS Certification #: _____
Person Notified: _____ Contacted By: _____
Turn Off Date/Time: _____ Turn On Date/Time: _____

Kit

Test Gauge Make: _____ Model: _____ Last Calibration Date: ____/____/____

Tester

I hereby certify that the Isolation / Shutoff Valves (SOV#1 and SOV #2) have been returned to the position in which they were found and that the test was done according to the procedure shown above required by the Water District/ Authority shown above; and the test readings are true and accurate to the best of my ability.

(Please Print)
Testing Company: _____ Phone #: _____

(Please Print)
Customer Name: _____ Phone #: _____

Tester Name: _____ (Please Print)

(Tester)
Signature: _____

(Customer)
Signature: _____