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** ☐ **Irrigation** ☐ **Fire** ☐	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: ___/___/___	o Leaked o Closed __PSID (RPZ)	o Leaked o Closed tight	o Opened @____PSID o Did not open
Maintenance of Devices Date: ___/___/___	o Cleaned o Repaired Material used____ ________________	o Cleaned o Repaired Material used____ ________________	o Cleaned o Repaired Material used____ ________________
Changed or New Device Installed (must be tested on line)	o DC Size___________ Model__________ Serial__________ Mfg.___________		o RPZ Size____________ Model___________ Serial___________ Mfg.____________
Final Test of Device Date: ___/___/___	o Closed tight ____PSID(RPZ)	o Closed tight	Opened at ________PSID

REMARKS:____

CERTIFICATION OF TESTER: **I hereby certify the above date 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: Neil Longo, Inspector **PLEASE INCLUDE THE ACCOUNT NUMBER**
Phone: 412.264.4300 x 117 **Fax: 412.262.9482**