INSPECTION, TESTING, AND CERTIFICATION OF WORK

(To be completed by the Contractor and saved in the Contractor's CMMS)

FACID/Building: NY065 Date of Visit: 03/29/18

Contractor Personnel on Site:

4. Ryan L Harrison
5.
6.
4.
5.
6.

Work Performed:

Inspection, Testing, and Certification

5. Backflow Prevention Testing (Qty 1) (Annual)
6. WO 3370
7.
8.

CERTIFICATION OF WORK

To be signed by the Contractor:

Print Name: Kevin Fawcett Date:

Signed: Kevin Fawcett

To be signed by Facility Manager:

I certify that the above named individuals representing the Contractor arrived on site and to the best of my knowledge, completed the stated work listed:

Print Name/Rank: RANIE G. ECKMAN Date: 29 MAR 18

Signed:

E-Mail: ranie.g.eckman.civ@mail.mil

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Public Water Supply Protection
Flanigan Square, 547 River Street, Room 400
Troy, New York 12180-2216

Report on Test and Maintenance of Backflow Prevention Device

Please use a separate form for each device.

For the year 2018
☐ Initial test - *Complete entire form*
☒ Annual test - *Complete Part A only*

PART A

Public Water Supply	Account No.	County	Block	Lot
Erie county water		Erie		

Facility Name: US Army Reserve Center
Address: 2393 Calvin Rd (Street) Tonawanda (City) 14150 (Zip)
Location of Device: Rm 108 closet

Device Information	Manufacturer	Type	Model	Size (in inches)	Serial Number
	Watts	☐ RPZ ☐ DCV	909 M1	2	450417

Line Pressure 45 psi

	Check Valve No. 1	Check Valve No. 2	Differential Pressure Relief Valve	Date
Test before repair	Leaked ☐ Closed tight ☒ Pressure drop across first check valve 10 psid	Leaked ☐ Closed tight ☒	Opened at 4 psid	05 29 18 (M D Y)
Describe repairs and materials used				Repaired by Name ____ Lic # ____ Date repaired: ____ (M D Y)
Final test	Closed tight ☐ Pressure drop across first check valve ____ psid	Closed tight ☐	Opened at ____ psid	Date ____ (M D Y)

Water Meter Number: 16256064
Meter Reading: 210972
Type of Service: (check one) ☒ Domestic • ☐ Fire • ☐ Other ____

Remarks (Describe deficiencies: bypasses, outlets before the device, connections between the device and point of entry, missing or inadequate airgaps, etc.)

Certification: This device ☒ meets, • ☐ does NOT meet, the requirements of an acceptable containment device at the time of testing

I hereby certify the foregoing data to be correct.

Print Name	Certified Tester No.	Signature	Expiration Date
Kevin Fennell	5895	Kevin Fennell	06/30/19

Property owners (or owners agent) certification that test was performed:

Print Name	Title	Signature	Telephone
Kyra L Harrison	Army Administrator	Kyra L Harrison	716-693-2228

PART B Certification that installation is in accordance with the approved plans. (To be completed by the design engineer or architect or water supplier.)

I hereby certify that this installation is in accordance with the approved plans.

Name	Title	Date (m d y)	NYS DOH Log #

License Number ____ Phone ( ) ____

Representing ____

Address ____

City ____ State ____ Zip ____

Signature ____

Describe minor installation changes

NOTE: Send one completed copy to the designated health department representative and one copy to the water supplier within 30 days of the testing device. Notify owner and water supplier immediately if device fails test and repairs cannot immediately be made.

DOH-1013(9/91)