WO # 2446 Asset #7272

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

PART A — **Please use a separate form for each device.**

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

Public Water Supply	Account No.	County	Block	Lot
~~Town of~~ Horseheads		Chemung		

Facility Name Alden D Allen Reserve Center
Address 3126 upper Lake Rd (Street) Horseheads (City) Zip 14845
Location of Device Room B107 Mech/Elec Room

Device Information	Manufacturer	Type	Model	Size (in inches)	Serial Number
	WATTS	☒ RPZ ☐ DCV	909	2	318399

	Check Valve No. 1	Check Valve No. 2	Differential Pressure Relief Valve	Line Pressure 68 psi
Test before repair	Leaked ☐ Closed tight ☒ Pressure drop across first check valve 15 psid	Leaked ☐ Closed tight ☒	Opened at 2.8 psid	Date 02 28 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	Meter Reading	Type of Service: (check one)
1635299	465180	(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
Adam Jones	0353	Adam Jones	7/31/2015

Property owner's (or owner's agent) certification that test was performed:

Print Name	Title	Signature	Telephone
Jodi Philipenko	Facility Coordinator	Jodi Philipenko	(607) 733-3515

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	Describe minor installation changes
Address	
City / State / Zip	
Signature	

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)