

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 _____

- ☐ Initial test - Complete entire form
☐ Annual test - Complete Part A only

Public Water Supply <u>Village of Penn Yan</u>		Account No.		County <u>Yates</u>	Block	Lot
Facility Name <u>Army Reserve Center</u>				Location of Device <u>Boiler Room</u>		
Address <u>198 Cornwell Rd Penn Yan NY</u> Street City Zip						
Device Information	Manufacturer <u>Watts</u>	Type <input checked="" type="checkbox"/> RPZ <input type="checkbox"/> DCV	Model <u>909</u>	Size (in inches) <u>2"</u>	Serial Number <u>754440</u>	
	Check Valve No. 1	Check Valve No. 2	Differential Pressure Relief Valve	Line Pressure _____ psi		
Test before repair	Leaked <input type="checkbox"/> Closed tight <input checked="" type="checkbox"/>	Leaked <input type="checkbox"/> Closed tight <input checked="" type="checkbox"/>	Opened at <u>2.6</u> psid	Date <u>03</u> <u>13</u> <u>18</u> M D Y		
	Pressure drop across first check valve <u>15</u> psid					
Describe repairs and materials used				Repaired by Name _____ Lic # _____ Date repaired: <u> </u> <u> </u> <u> </u> M D Y		
Final test	Closed tight <input type="checkbox"/>	Closed tight <input type="checkbox"/>	Opened at _____ psid	Date <u> </u> <u> </u> <u> </u> M D Y		
	Pressure drop across first check valve _____ psid					
Water Meter Number <u>95624234</u>		Meter Reading <u>1220900</u>	Type of Service: (check one) <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> meets, • <input type="checkbox"/> does NOT meet, the requirements of an acceptable containment device at the time of testing I hereby certify the foregoing data to be correct. <u>8353</u> <u>Adam Jones</u> Print Name <u>Adam Jones</u> Signature <u>7 31 2018</u> Expiration Date						
Property owners (or owners agent) certification that test was performed: <u>John F. Granata</u> Print Name <u>AFOS</u> Title <u>J. F. Granata</u> Signature <u>956 620 5314</u> Telephone						

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	NYS DOH Log #
License Number	Phone ()	m d y	
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)