

**CERTIFICATION OF WORK
PREVENTIVE MAINTENANCE**

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

FACID/Building: NY035-01 Date of Visit: 9-23-19

Contractor Personnel on Site:

1. Patrick Brown 3. _____
2. _____ 4. _____

Work Performed:

Preventive Maintenance - Services Completed (Annual, Quarterly, Monthly, equipment identification, etc.)

1. WO 5132 ASSET 9846
2. WO 5156 ASSET 9846
3. Backflow RPZ Failed and needs to
4. be replaced
5. _____

CERTIFICATION OF WORK

To be signed by the Contractor:

Print Name: Patrick Brown Date: 9-23-19

Signed: _____

To be signed by Facility Manager:

By signing the Certification of Work, the said government representative signature does not constitute acceptance of any work performed by the contractor, it only acknowledges that the contractor was on-site during the identified timeline:

Print Name/Rank: Doug Rushlo Date: 9-23-19

Signed: _____

E-Mail: _____

Report on Test and Maintenance of Backflow Prevention Device

PART A

Please use a separate form for each device.

For the year 2019

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

Public Water Supply <u>CLWA</u>		Account No. <u>N4035</u>		County <u>Onondaga</u>	Block	Lot												
Facility Name <u>1LT McConnell USARC/AMSA</u>				Location of Device <u>Boiler room Suspended in the air</u>														
Address <u>420 Electronics Parkway Liverpool NY 13088</u>																		
Device Information		Manufacturer <u>Watts</u>	Type <input checked="" type="checkbox"/> RPZ <input type="checkbox"/> DCV	Model <u>LF909M1ZTRP</u>	Size (in inches) <u>1 1/2"</u>	Serial Number <u>03678</u>												
Check Valve No. 1		Check Valve No. 2		Differential Pressure Relief Valve		Line Pressure <u>68</u> psi												
Test before repair	Leaked <input checked="" type="checkbox"/> Closed tight <input type="checkbox"/>		Leaked <input checked="" type="checkbox"/> Closed tight <input type="checkbox"/>		Opened at _____ psid <u>Never closed always open</u>													
	Pressure drop across first check valve <u>1.2</u> psid		Date <table border="1"><tr><td>0</td><td>9</td><td>2</td><td>3</td><td>1</td><td>9</td></tr><tr><td>M</td><td>D</td><td>Y</td><td colspan="3"></td></tr></table>				0	9	2	3	1	9	M	D	Y			
0	9	2	3	1	9													
M	D	Y																
Describe repairs and materials used					Repaired by Name _____ Lic # _____ Date repaired: <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>M</td><td>D</td><td>Y</td><td colspan="3"></td></tr></table>								M	D	Y			
M	D	Y																
Final test	Closed tight <input type="checkbox"/>		Closed tight <input type="checkbox"/>		Opened at _____ psid													
	Pressure drop across first check valve _____ psid		Date <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>M</td><td>D</td><td>Y</td><td colspan="3"></td></tr></table>										M	D	Y			
M	D	Y																
Water Meter Number		Meter Reading		Type of Service: (check one) <input checked="" type="checkbox"/> Domestic <input checked="" type="checkbox"/> Fire <input checked="" type="checkbox"/> 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 type="checkbox"/> meets, <input checked="" 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>Patrice Brown</u> <u>12561</u> <u>06/30/2021</u> Print Name Certified Tester No. Signature Expiration Date																		
Property owners (or owners agent) certification that test was performed: <u>Doug Hisho</u> <u>AFOS</u> <u>[Signature]</u> <u>[]</u> Print Name Title Signature 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)