

**CERTIFICATION OF WORK**  
(To be completed by the Contractor and saved in the Contractor's CMMS)

**INSPECTION, TESTING, AND CERTIFICATION OF WORK**  
(To be completed by the Contractor and saved in the Contractor's CMMS)

FACID/Building: NY052 Date of Visit: 2-8-19

Contractor Personnel on Site:

1. <u>Patrick Brown</u>	4. _____
2. _____	5. _____
3. _____	6. _____

**Work Performed:**

**Inspection, Testing, and Certification**

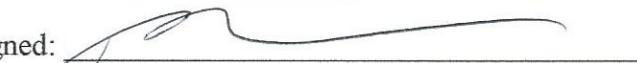
1. Backflow Prevention Testing (Qty 1) (Annual) WO 7282 Asset 7254
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

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**CERTIFICATION OF WORK**

To be signed by the Contractor:

Print Name: Patrick Brown Date: 2-8-19

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: John F. Granata AFCS Date: 8FEB19

Signed: 

E-Mail: john.f.granata.cfr@mail.mil

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 <i>Pen Yar</i>		Account No.	County <i>Yates</i>	Block	Lot
Facility Name <i>Olaf A. Fredersjekk LLC</i>		Location of Device <i>Boiler room</i>			
Address <i>198 Cornwell St, Pen Yar, NY 14527</i>		Street	City	Zip	
Device Information	Manufacturer <i>Watts</i>	Type <input checked="" type="checkbox"/> RPZ <input type="checkbox"/> DCV	Model <i>909M1 QTRP</i>	Size (in inches) <i>2</i>	Serial Number <i>454440</i>
	Check Valve No. 1	Check Valve No. 2	Differential Pressure Relief Valve	Line Pressure <u>66</u> 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>2.2</u> psid	Date <u>02 08 19</u> M D Y	
	Pressure drop across first check valve <u>2.4</u> psid				
Describe repairs and materials used					Repaired by Name _____ Lic # _____ Date repaired: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> M D Y
Final test	Closed tight <input type="checkbox"/> Pressure drop across first check valve _____ psid	Closed tight <input type="checkbox"/>	Opened at _____ psid	Date <u>  </u> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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  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.

*Patrick Brown*

*12561*

*Signature*

*6/30/21*

Expiration Date

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

*John F. Granata*

*AFOS*

Print Name

Title

*John F. Deaf*  
*905886642*

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	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	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)

