

Return Reports to:
 City of Cañon City Water Department
 P.O. Box 1460, 81215
 backflowreporting@canoncity.org
 P: 719-269-9022 F: 719-269-9034
 Office Hours: M-F 7am-3:30pm

Assembly Serial # _____
 Test Date / Time _____
 Tester Certification # _____
 Assembly Test Results Pass *Fail

(please print [!] with BLOCK LETTERING)

Account	Facility Name: _____				Meter #:	
	Facility Address: _____			City: _____		
	Contact Person: _____				Phone: _____	
Assembly	Make: _____	Model: _____				
	Type: <input type="checkbox"/> RP <input type="checkbox"/> DC <input type="checkbox"/> PVB <input type="checkbox"/> ÁJXÓ <input type="checkbox"/> Air Gap					
	Size: _____	Date Installed: _____	Type of Use	Protection	Orientation	
	<input type="checkbox"/> New <input type="checkbox"/> Existing		<input type="checkbox"/> Domestic	<input type="checkbox"/> Containment	<input type="checkbox"/> Inlet <input type="checkbox"/> Outlet	
	Previous Assembly #: _____		<input type="checkbox"/> Fire <input type="checkbox"/> Glycol	<input type="checkbox"/> Containment by Isolation	<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical Up	
Location: _____		<input type="checkbox"/> Irrigation	<input type="checkbox"/> Isolation	<input type="checkbox"/> Vertical Down <input type="checkbox"/> Approved: Y <input type="checkbox"/> N <input type="checkbox"/>		
Testing & Maintenance	Line PSI:	Initial Test Results		Re-Test Results		
		Tightness	Differential	Tightness	Differential	
	Check Valve #1 (RP, DC, PVB)	<input type="checkbox"/> Leak <input type="checkbox"/> Tight		<input type="checkbox"/> Leak <input type="checkbox"/> Tight		
	Check Valve #2 (RP, DC)	<input type="checkbox"/> Leak <input type="checkbox"/> Tight		<input type="checkbox"/> Leak <input type="checkbox"/> Tight		
	Relief Valve (RP)					
	Buffer (RP)					
	Air Inlet (PVB)					
	Shutoff Valve #1: <input type="checkbox"/> Tight <input type="checkbox"/> Leaking <input type="checkbox"/> Replaced			Shutoff Valve #2: <input type="checkbox"/> Tight <input type="checkbox"/> Leaking <input type="checkbox"/> Replaced		
	Backpressure: <input type="checkbox"/> Yes <input type="checkbox"/> No	Test Procedure: <input type="checkbox"/> ABPA: <input type="checkbox"/> ASSE:				
	Comments: _____					
Notification	Alarm Company/Fire Department: _____					
	Person Notified: _____		Contacted By: _____			
Test Kit	Turn Off Date/Time: _____		Turn On Date/Time: _____			
	Test Kit Make: _____		Model: _____			
Serial #: _____		Last Calibration Date: _____				
Tester	Tester certifies this assembly has been tested with the above listed procedure and verifies the isolation valves were returned to pre-test orientation.					
	Testing Company: _____					
	Tester Name: _____		Phone: _____			
	Signature: _____		Certificate Expiration Date: _____			

Testing Company: Submit by e-mail (preferred) to c@canoncity.org,
 type "Backflow Test Reports" in the subject line OR submit by Fax to (719) 269-9022.

* FAILED test results must be reported to c@canoncity.org within 24 hours of failure at (719) 269-9022.