CITY OF BASTROP

Water and Wastewater Dept.
P.O. Box 427 / 300 Water Street - Bastrop, Texas 78602
Ph: (512) 332-8960 Fx: (512) 332-0279
PWS I.D. # TX0110001

The following form must be completed for each assembly tested. A signed and dated original must be submitted to the City of Bastrop's Water and Wastewater Department within five (5) working days of the test, repair or overhaul.

BACKFLOW PREVENTION ASSEMBLY TEST AND MAINTENANCE REPORT

Name of Water Customer:__________________________________________
Address:________________________________________________________
Telephone: ______________________ Account# _______________________

The backflow prevention assembly detailed below has been tested and maintained as required by Commission regulations and is certified to be operating within acceptable parameters.

TYPE OF ASSEMBLY

☐ Reduced Pressure Principle    ☐ Reduced Pressure Principle-Detector
☐ Double Check Valve           ☐ Double Check-Detector
☐ Pressure Vacuum Breaker      ☐ Spill-Resistant Pressure Vacuum Breaker

Manufacturer:____________________________________________________ Size:_____________________________________________________
Model#:____________________________________________________ Location:___________________________________________________
Serial#:____________________________________________________

Is the assembly installed in accordance with manufacturer recommendations and/or local codes? ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>Reduced Pressure Principle Assembly</th>
<th>Relief Valve</th>
<th>Pressure Vacuum Breaker</th>
</tr>
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<tbody>
<tr>
<td>Double Check Valve Assembly</td>
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<td></td>
</tr>
<tr>
<td>Initial Test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pass</td>
<td>Held at _____ psid</td>
<td>Held at _____ psid</td>
</tr>
<tr>
<td>Fail</td>
<td>Closed Tight ☐</td>
<td>Closed Tight ☐</td>
</tr>
<tr>
<td>Repairs and Materials Used**</td>
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<td>Test After Repair</td>
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<tr>
<td>Held at _____ psid</td>
<td>Held at _____ psid</td>
<td>Opened at _____ psid</td>
</tr>
<tr>
<td>Closed Tight ☐</td>
<td>Closed Tight ☐</td>
<td></td>
</tr>
</tbody>
</table>

Test gauge used: Make/Model________________ SN:________________ Date Tested for Accuracy:______________

Remarks:__________________________________________________________________________________________

The above is certified to be true at the time of testing.

Firm Name_________________________________________ Certified Tester Name (Print/Type)_____________________
Firm Address_______________________________________ Certified Tester Name (Signature)_______________________
City, State, Zip Code_______________________________ Licensed Tester #____ Date of Test______________
Firm Phone #_______________________________________

* TEST RECORDS MUST BE KEPT FOR AT LEAST THREE YEARS
** USE ONLY MANUFACTURER'S REPLACEMENT PARTS