

**TOWN OF SPRING LAKE PUBLIC WORKS
CROSS CONNECTION CONTROL PROGRAM
TEST AND MAINTENANCE REPORT**

CUSTOMER: _____

STREET ADDRESS: _____

LOCATION OF ASSEMBLY: _____

TYPE OF ASSEMBLY: RP DC PVB SIZE: _____

MANUFACTURER: _____ MODEL: _____ SERIAL NO. _____

TEST EQUIPMENT MAKE/MODEL: _____ SERIAL#: _____ CALIBRATION DATE: _____

RELIEF VALVE	CHECK VALVE #1	CHECK VALVE #2	PRESSURE VACUUM BREAKER
OPENED AT: _____ PSID BUFFER _____ PSID DID NOT OPEN <input type="checkbox"/>	<input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT DIFF. PRESSURE ACROSS CHECK VALVE: _____ PSID	<input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT DIFF. PRESSURE ACROSS CHECK VALVE: _____ PSID	AIR INLET OPENED AT: _____ PSID DID NOT OPEN <input type="checkbox"/> CHECK VALVE: LEAKED <input type="checkbox"/> HELD AT _____ PSID
<input type="checkbox"/> CLEANED ONLY REPLACED: RUBBER KIT <input type="checkbox"/> RV ASSEMBLY <input type="checkbox"/>	<input type="checkbox"/> CLEANED ONLY REPLACED: RUBBER KIT <input type="checkbox"/> CV ASSEMBLY <input type="checkbox"/>	<input type="checkbox"/> CLEANED ONLY REPLACED: RUBBER KIT <input type="checkbox"/> CV ASSEMBLY <input type="checkbox"/>	<input type="checkbox"/> CLEANED ONLY REPLACED: RUBBER KIT <input type="checkbox"/> CV ASSEMBLY <input type="checkbox"/>
OPENED AT: _____ PSID BUFFER _____ PSID	<input type="checkbox"/> CLOSED TIGHT _____ PSID	<input type="checkbox"/> CLOSED TIGHT _____ PSID	AIR INLET _____ PSID CHECK VALVE _____ PSID
SHUT OFF VALVE #1 <input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT		SHUT OFF VALVE #2 <input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT	

NOTE: ALL REPAIRS MUST BE COMPLETED WITHIN THIRTY DAYS.

REMARKS: _____

I HEREBY CERTIFY THAT AT THE DATE AND TIME OF THE TEST INDICATED, THIS DATA IS ACCURATE AND REFLECTS THE PROPER OPERATION AND MAINTENANCE OF THE ASSEMBLY PER CURRENT INDUSTRY STANDARDS. I ALSO CERTIFY THAT THE #1 AND #2 SHUTOFF VALVES HAVE BEEN LEFT IN THE FULLY OPENED POSITION.

INITIAL TEST BY: _____ CERTIFIED TESTER NO. _____ DATE: _____

REPAIRED BY: _____ CERTIFIED TESTER NO. _____ DATE: _____

FINAL TEST BY: _____ CERTIFIED TESTER NO. _____ DATE: _____

DOMESTIC FIRE LAWN IRRIGATION NEW TEST RECERTIFICATION TEST

WATER METER NUMBER: _____ PLUMBING PERMIT NUMBER: _____

TEST KIT DIFFERENTIAL ELECTRONIC LINE PRESSURE: _____

TIME OF DAY: _____ AM PM SIGNATURE OF TESTER: _____

PLEASE INCLUDE A COPY OF THE TESTERS CERTIFICATION AND TEST EQUIPMENT CALIBRATION WITH THIS FORM.

**RETURN TO: TOWN OF SPRING LAKE CROSS CONNECTION PROGRAM
300 RUTH STREET
SPRING LAKE, NORTH CAROLINA 28390**

**drosario@townofspringlake.com
PHONE: (910) 985-1804**