

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 [/ &] ^ Á with BLOCK LETTERING)

Account	Facility Name: _____		Meter #: _____			
	Facility Address: _____		City: _____			
	Contact Person: _____		Phone: _____			
Assembly	Make: _____ Model: _____		<u>Type of Use</u>			
	Type: <input type="checkbox"/> RP <input type="checkbox"/> DC <input type="checkbox"/> PVB <input type="checkbox"/> Air Gap		<u>Protection</u>			
	Size: _____ Date Installed: _____		<u>Orientation</u>			
Testing & Maintenance	<input type="checkbox"/> New <input type="checkbox"/> Existing		<input type="checkbox"/> Domestic			
	Previous Assembly #: _____		<input type="checkbox"/> Fire <input type="checkbox"/> Glycol			
	Location: _____		<input type="checkbox"/> Irrigation			
Testing & Maintenance	Line		Repairs			
	PSI:				Re-Test Results	
			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: _____			
	Turn Off Date/Time: _____		Turn On Date/Time: _____			
Test Kit	Test Kit Make: _____		Model: _____			
	Serial #: _____		Last Calibration Date: _____			
Tester	<i>Tester certifies this assembly has been tested with the above listed procedure and verifies the isolation valves were returned to pre-test orientation.</i>					
	Testing Company: _____					
	Tester Name: _____		Phone: _____			
Signature: _____		Certificate Expiration Date: _____				

Testing Company: Submit by e-mail (preferred) to backflowreporting@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 (719) 269-9022 within 24 hours of failure at (719) 269-9022.**