CHEROKEE METROPOLITAN DISTRICT

6250 Palmer Park Blvd. Colorado Springs, CO 80915-1721
Telephone: (719) 597-5080 Fax: (719) 597-5145

CROSS CONNECTIONS CONTROL PROGRAM

Backflow Prevention Device Assembly Test & Maintenance Report

SERVICE STREET ADDRESS _____ ZIP _____

BUSINESS NAME _____

SERVICE CONTACT PERSON _____ SERVICE PHONE # _____

OWNER / MGMT COMPANY / CONTRACTOR (If different from above) _____ BILLING CONTACT PERSON _____

BILLING ADDRESS _____ STREET _____ CITY _____ STATE _____ ZIP _____

The cross-connection control assembly device detailed below has been tested and maintained as required by the regulations of the State of Colorado Department of Public Health and Environment, and is certified to comply with these regulations.

REPLACEMENT FOR # _____ MAKE OF DEVICE _____ MODEL NUMBER _____ SIZE _____

NEW INSTALLATION ☐

EXISTING INSTALLATION ☐ SERIAL NUMBER _____ LINE PRESSURE _____

LOCATION OF DEVICE ON PROPERTY _____

INSTALLATION TYPE: Domestic ☐ Fire ☐ Irrigation ☐ Containment ☐ Isolation ☐ PROCESS _____

PRESSURE VACUUM BREAKER		REDUCED PRESSURE ZONE		
AIR INLET	**CHECK VALVE**	**FIRST CHECK**	**SECOND CHECK**	**RELIEF CHECK**
OPENED _____PSID	First Test_____PSID With Flow_____PSID	DIRECTION OF FLOW _____PSID	DIRECTION OF FLOW_____PSID HELD TIGHT ☐ LEAKED ☐	_____PSID
REPAIRS: OR COMMENTS:		REPAIRS: OR COMMENTS:		

DUAL CHECK (Single Family Residential Only)	FIRST CHECK	SECOND CHECK
CLEANED CHECKS_____ REPLACED CHECKS_____	DIRECTION OF FLOW_____PSID	DIRECTION OF FLOW_____PSID
REPAIRS: OR COMMENTS:	REPAIRS: OR COMMENTS:	

PASSED ☐ FAILED ☐ If device failed, name of person notified? _____

The above is certified to be true by:

COMPANY: _____

ADDRESS: _____

PHONE NO.: _____

NAME: _____

CITY: _____

STATE: _____ ZIP: _____

TEST DATE: _____

CERTIFIED TESTER:

NO: _____ EXP: _____

NAME: _____
Please Print

_____
Signature

TYPE OF TEST GAUGE: _____

LAST CALIBRATION DATE: _____/_____/_____

Copies to: White: Cherokee Yello: Tester Pink: Customer

Rev 10/31/13