

Tester's Signature: _

Development Services Department: Building

T: 519-634-8444 Email: building@wilmot.ca

Backflow Prevention Device Inspection and Testing Report

Address of Property Owner's Name & Mailing Address: Tenant (if applicable): TESTER INFORMATION Company Name & Mailing Address: Individual's Name: Certificate Number: Device Information Company Name & Mailing Address: Individual's Name: Certificate Number: Date of Last Calibration: Device Information Test Gauge Serial No: Date of Last Calibration: Date of Last Calibration: Device Information Type: RP DCVA PVB Line Pressure: Size: Serial No.: TEST INFORMATION Date of Test: Type of Test: Infilial Annual Re-Test Reduced Pressure Principle Assembly Check Valve #1 Check Infilial Closed Tight Press. Diff #2 Check Infilial Device Infilial	PROPERTY INFORMATION	o zorosprion ostrioso mumi i radys si test
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Location of Device: Type:	Certificate Number:	Date of Last Calibration:
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Tester's Name (Print):	Tester's Name (Print):	

Date:__