

WARREN COUNTY HEALTH DISTRICT  
 DIVISION OF PLUMBING  
 416 S. East Street, Lebanon, Ohio 45036  
 Phone: (513) 695-1475

- BSI Online will serve as the primary point of contact for the WCHD backflow program & can be contacted below: **Testing Company Support**
  - Phone: 800-414-4990
  - Fax: 888-414-4990
  - Email: [bsionline@backflow.com](mailto:bsionline@backflow.com)

**\* PLEASE FILL OUT COMPLETELY \***

- |  |                                |
|--|--------------------------------|
| <input type="checkbox"/> Reduced Pressure Principle Backflow Preventor | <u>WCHD MONITORS ISOLATION</u> |
| <input type="checkbox"/> Double Check Valve Assembly                   | <u>DEVICES ONLY</u>            |
| <input type="checkbox"/> Pressure Vacuum Breaker                       |                                |

Name of Owner/Occupant of Device: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Address of Device \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Make and Model: \_\_\_\_\_ Size: \_\_\_\_\_

Serial No: \_\_\_\_\_ Date Installed: \_\_\_\_\_

Exact Location of Device \_\_\_\_\_

Line Pressure _____ psi	Check Valve #1	Check Valve #2	Differential Pressure Relief Valve
Test Before Repair	Leaked ( ) Closed Tight ( )	Leaked ( ) Closed Tight ( )	Opened at _____ psi Reduced Pressure
Describe Repair			
Material Used			
Final Test	Closed Tight ( )	Closed Tight ( )	Opened at _____ psi Reduced Pressure

**CERTIFICATION** (tester)

I hereby certify the above data to be correct and that the above backflow prevention device is in proper operating condition.

Tester: (signature): \_\_\_\_\_ State of Ohio Cert. No: \_\_\_\_\_

Tester: (print): \_\_\_\_\_ Phone # \_\_\_\_\_ Date: \_\_\_\_\_

Tester Email: \_\_\_\_\_

**CERTIFICATION** (company)

I hereby certify that the above backflow prevention device has been in constant use at this location during the entire prescribed interval between test periods and during that period this device was not by-passed, made inoperative or removed without proper authorization. All defects found during the operation period or during tests of device were satisfactorily corrected without delay. I further certify that I have the responsibility and authority to insure the above.

Owner/Officer (signature): \_\_\_\_\_ Title: \_\_\_\_\_

Owner/Officer (print): \_\_\_\_\_ Date: \_\_\_\_\_