PRESSURE VACUUM BREAKER
TEST REPORT LOG

TEST KIT TYPE ___________________ TEST KIT SERIAL NO. ___________________

DATE CALIBRATED ______/____/______ CALIBRATED BY _____________________________

NOTE: TEST KITS MUST BE TESTED FOR CALIBRATION EVERY 12 MONTHS

BUSINESS NAME ____________________

CUSTOMER ADDRESS ___________________ ZIP CODE ___________________

RESPONSIBLE PERSON ___________________ PHONE NO. ____________________

DEVICE MANUFACTURER ___________ MODEL NO. ___________ SERIAL NO. ___________

SIZE ___________ LOCATION OF DEVICE ___________

PRESSURE VACUUM BREAKER

Air Inlet ______ PSID

☐ Did not open

Check Valve ______ PSID

☐ Leaked

☐ Cleaned

☐ Replaced: (Old S/N) ___________

Air Inlet ______ PSID

Check Valve ______ PSID

Shut off Valve #2

☐ Leaked ☐ Closed Tight

Comments: _______________________________________________________________

This Assembly: ☐ _________ PASSED ☐ _________ FAILED

I HEREBY CERTIFY THE ABOVE INFORMATION TO BE CORRECT.

______________________________         ____________________________
FIRM OF TESTER                SIGNATURE OF TESTER

______________________________         ____________________________
CERTIFICATE NO.                PHONE NO.