



CITY OF HARRISONBURG
**COMMUNITY
DEVELOPMENT**

**CROSS CONNECTION AND BACKFLOW
PREVENTION CONTROL PROGRAM**
<https://harrisonburgva.gov/backflow-prevention-device>

OWNER INFORMATION			
Owner/Agent Name _____		Phone _____	
Mailing Address _____		E-Mail _____	
City _____	State _____	Zip _____	
BACKFLOW PREVENTION DEVICE LOCATION			
Address: _____			
Location on Premises: _____			
BACKFLOW PREVENTION DEVICE INFORMATION Permit number, if available: _____			
MFG/Make: _____		Model: _____	Serial No. _____ Size: _____
System Type: (Check one) <input type="checkbox"/> Boiler <input type="checkbox"/> Domestic <input type="checkbox"/> Fire Suppression <input type="checkbox"/> Fire Bypass Meter <input type="checkbox"/> HVAC <input type="checkbox"/> Lawn Irrigation <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Other: _____			
Does this system use any chemicals, such as glycol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what chemical? _____			
Check Type: <input type="checkbox"/> Double check valve assembly <input type="checkbox"/> Double check valve assembly for fire protection systems valve assembly <input type="checkbox"/> Double check valve detector check assembly <input type="checkbox"/> Pressure vacuum breaker <input type="checkbox"/> Spill resistant pressure vacuum breaker <input type="checkbox"/> Reduced Pressure principal <input type="checkbox"/> Reduced pressure principle for fire protection systems <input type="checkbox"/> Single check valve assembly for fire protection systems (only for Class 1 and residential partial flow thru systems)			
HAZARD CATEGORY			
Check one of the following: <input type="checkbox"/> Low (involves substance that constitutes a nuisance & results in only reduced aesthetic qualities of the water) <input type="checkbox"/> Medium (any low hazard with low probability of becoming severe hazard) <input type="checkbox"/> High (water with additives or substances that, under any concentration, can create a danger to health)			
TEST RESULTS			
Inspection date: _____		Status: <input type="checkbox"/> Passed <input type="checkbox"/> Failed	
If failed, why? _____			
Was the device repaired: <input type="checkbox"/> Yes <input type="checkbox"/> No			
What repair was done? _____			
Static line pressure _____ PSI _____		Buffer zone pressure _____ PSI _____	
Check valve #1	Relief valve	Check valve #2	Pressure vacuum breaker
_____ Leaked	Opened at _____ PSI	_____ Leaked	Air inlet
_____ Closed tight	_____ Didn't open	_____ Closed tight	Did not open _____ or
Gauge pressure across	Outlet shut-off valve	Gauge pressure across	Opened at _____ PSI
Check valve #1	_____ Leaked	Check valve #2	Check valve
_____ PSID	_____ Closed tight	_____ PSID	_____ Leaked or
			Held at _____ PSI

TESTER INFORMATION

Owner/Agent Name

Phone

Mailing Address

E-Mail

City

State

Zip

DPOR Registration Number**TEST GAUGE INFORMATION**

MFG/Make: _____ Serial #: _____ Calibration Date: _____

Calibration Company Name: _____