



TESTING AND INSPECTION REPORT

. DOUBLE CHECK VALUE ASSEMBLY/
PRESSURE VACUUM BREAKER

. REDUCED PRESSURE PRINCIPLE BACKFLOW
PRECAUTION ASSEMBLY

TOWN OF MARKHAM
BUILDING STANDARDS
101 TOWN CENTRE BLVD.
MARKHAM, ONTARIO L3R 9W3
TEL - 905 - 475-4850 FAX - 905 - 415-7501

ADDRESS OF DEVICE				OCCUPANT				CONTACT				TELEPHONE NUMBER			
OWNER				ADDRESS OF OWNER				POSTAL CODE				TELEPHONE NUMBER			
SERIAL NUMBER		MAKE		MODEL		SIZE		INSTALL DATE YYYY MM DD		BUILDING					
INSTALLED ON WHAT SYSTEM <input type="checkbox"/> DOMESTIC <input type="checkbox"/> FIRE <input type="checkbox"/> IRRIGATION <input type="checkbox"/> OTHER _____								LOCATION OF ASSEMBLY (ie. ROOM NUMBER)							
TESTER'S CERTIFICATION NUMBER				TESTER'S EQUIPMENT NUMBER				TESTER'S NAME				TELEPHONE NUMBER			
BUSINESS NAME				BUSINESS ADDRESS				POSTAL CODE				FAX NUMBER			
TYPE OF TEST <input type="checkbox"/> INITIAL <input type="checkbox"/> ANNUAL <input type="checkbox"/> REPAIR <input type="checkbox"/> REPLACES SERIAL # _____								TYPE OF DEVICE <input type="checkbox"/> RP <input type="checkbox"/> DCVA <input type="checkbox"/> PVB <input type="checkbox"/> SRPVB							
RP		CHECK VALVE 2		CHECK VALVE 1		DCV				PVB ASSEMBLY				SHUT OFF VALVES	
		<input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT		<input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT											
<input type="checkbox"/> RELIEF VALVE FAILED TO OPEN						CHECK VALVE 1		CHECK VALVE 2		AIR INLET VALVE		CHECK VALVE		#1	#2
TEST	PRESSURE DIFFERENTIAL ACROSS 1ST CHECK VALVE (no flow) A _____ Psi kPa				<input type="checkbox"/> LEAKED		<input type="checkbox"/> LEAKED		<input type="checkbox"/> FAILED TO OPEN		<input type="checkbox"/> LEAKED		<input type="checkbox"/> LEAKED	<input type="checkbox"/>	
	<input type="checkbox"/> OPENED, OPENING POINT OF RELIEF VALVE (2 psi or greater) -B _____ Psi kPa				<input type="checkbox"/> CLOSED TIGHT		<input type="checkbox"/> CLOSED TIGHT		<input type="checkbox"/> OPENED		<input type="checkbox"/> CLOSED TIGHT		<input type="checkbox"/> CLOSED	<input type="checkbox"/>	
	BUFFER (3 psi or greater) A - B = C = C _____ Psi kPa														
STATIC INLET LINE PRESSURE AT TIME OF TEST _____ kPa Psi				TEST RESULT <input type="checkbox"/> PASSED <input type="checkbox"/> FAILED				TEST DATE				YYYY	MM	DD	
If the device fails the initial test for any reason, complete the sections below, noting the repairs and retest results															
REPAIR	CHECK APPLICABLE VALVE(S) <input type="checkbox"/> RELIEF VALVE <input type="checkbox"/> CHECK VALVE # 1 <input type="checkbox"/> CHECK VALVE # 2 <input type="checkbox"/> AIR INLET VALVE <input type="checkbox"/> SHUT OFF VALVE														
	CHECK APPLICABLE REPAIR <input type="checkbox"/> CLEANED; REPLACED <input type="checkbox"/> DISC <input type="checkbox"/> SPRING <input type="checkbox"/> DIAPHRAGM <input type="checkbox"/> SEAT <input type="checkbox"/> GUIDE <input type="checkbox"/> O-RINGS <input type="checkbox"/> POPPET <input type="checkbox"/> REPAIR														
RP ASSEMBLY		CHECK VALVE 2		CHECK VALVE 1		DCV				PVB ASSEMBLY				SHUT OFF VALVES	
		<input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT		<input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT											
<input type="checkbox"/> RELIEF VALVE FAILED TO OPEN						CHECK VALVE 1		CHECK VALVE 2		AIR INLET VALVE		CHECK VALVE		#1	#2
RETEST	PRESSURE DIFFERENTIAL ACROSS 1ST CHECK VALVE (no flow) A _____ Psi kPa				<input type="checkbox"/> LEAKED		<input type="checkbox"/> LEAKED		<input type="checkbox"/> FAILED TO OPEN		<input type="checkbox"/> LEAKED		<input type="checkbox"/> LEAKED	<input type="checkbox"/>	
	<input type="checkbox"/> OPENED, OPENING POINT OF RELIEF VALVE (2 psi or greater) -B _____ Psi kPa				<input type="checkbox"/> CLOSED TIGHT		<input type="checkbox"/> CLOSED TIGHT		<input type="checkbox"/> OPENED		<input type="checkbox"/> CLOSED TIGHT		<input type="checkbox"/> CLOSED	<input type="checkbox"/>	
	BUFFER (3 psi or greater) A - B = C = C _____ Psi kPa														
STATIC INLET LINE PRESSURE AT TIME OF TEST _____ kPa Psi				RETEST RESULT <input type="checkbox"/> PASSED <input type="checkbox"/> FAILED				RETEST DATE				YYYY	MM	DD	
I hereby declare that the information provided herein is true and certify that I have tested the above assembly in accordance with Can/CSA-B64. 10-01				SIGNATURE OF OWNER/TENANT _____				REMARKS/COMMENTS							
Signature of Certified Tester _____ Date YY MM DD				DATE _____											
TESTING FREQUENCY <input type="checkbox"/> INITIAL <input type="checkbox"/> ANNUAL				INSPECTOR'S SIGNATURE _____				DATE _____				BUILDING PERMIT NUMBER _____			

Personal information collected in this form and schedules is collected under the authority of subsection 8(1.1) of the Building Code Act, 1992 and will be used in the administration and enforcement of the Building Code Act, 1992. Questions about the collection of personal information may be addressed to: a) the Chief Building Official of the municipality or upper-tier municipality to which this application is being made, or, b) the inspector having the powers and duties of a chief building official in relations to sewage systems or pl for an upper-tier municipality, board of health or conservation authority to whom this application is made, or, c) Director, Building and Development Branch, Ministry of Municipal Affairs and Housing 777 Bay St., 2nd floor, Toronto, M5G 2E5 (416) 585-6

WHITE - MARKHAM BUILDING STANDARDS DEPARTMENT

YELLOW - TESTER

PINK - OCCUPANT OR OWNER