



CROSS CONNECTION CONTROL TESTING AND INSPECTION REPORT

THE CORP. OF THE CITY OF CAMBRIDGE
 Planning Services Department
 50 Dickson Street, P.O. Box 669
 Cambridge ON N1R 5W8
 Tel: 519-740-4613 Fax: 519-622-6184

ADDRESS OF DEVICE				OCCUPANT				CONTACT				TELEPHONE NUMBER						
OWNER				ADDRESS OF OWNER				POSTAL CODE				FAX 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 (i.e. ROOM NUMBER)										
TESTER'S OWWA NUMBER				TESTER'S KIT CALIBRATION DATE				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 <input type="checkbox"/> RPF <input type="checkbox"/> DCVAF <input type="checkbox"/> SCVAF										
T E S T	RP/RPF ASSEMBLY				CHECK VALVE 2		CHECK VALVE 1		DCVA, DCVAF, SCVAF				PVB / SRPVB ASSEMBLY		SHUT OFF VALVES			
	<input type="checkbox"/> RELIEF VALVE FAILED TO OPEN				<input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT		<input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT		CHECK VALVE 1		CHECK VALVE 2		AIR INLET VALVE		CHECK VALVE		#1 #2	
	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								DIFF psi _____		DIFF psi _____		DIFF psi _____		DIFF psi _____		<input type="checkbox"/> CLOSED <input type="checkbox"/>	
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				
R E P A I R	If the device fails the initial test for any reason, complete the sections below, noting the repairs and retest results																	
	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 KIT			
R E T E S T	RP/RPF ASSEMBLY				CHECK VALVE 2		CHECK VALVE 1		DCVA, DCVAF, SCVAF				PVB / SRPVB ASSEMBLY		SHUT OFF VALVES			
	<input type="checkbox"/> RELIEF VALVE FAILED TO OPEN				<input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT		<input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT		CHECK VALVE 1		CHECK VALVE 2		AIR INLET VALVE		CHECK VALVE		#1 #2	
	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								DIFF psi _____		DIFF psi _____		DIFF psi _____		DIFF psi _____		<input type="checkbox"/> CLOSED <input type="checkbox"/>	
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 certify the above device has been tested in accordance with <u>The City of Cambridge</u> Bylaw 146-03																		
SIGNATURE OF CERTIFIED TESTER				DATE YYYY MM DD		SIGNATURE OF OWNER / TENANT				DATE YYYY MM DD								
REMARKS/COMMENTS																		
FOR OFFICE USE ONLY				INSPECTOR'S SIGNATURE				DATE YYYY MM DD										

DISTRIBUTION:
WHITE - Cross Connection Control Officer

CANARY - Certified Tester
PINK - Occupant or Owner

The personal information on this form is collected under the authority of the Freedom of Information and Protection of Privacy Act, Section 33(c), and is used solely for the purpose of information to record test details and results.
 For additional information contact the City's Corporate Records Co-ordinator/Deputy Clerk in the Clerk's Division at 519-740-4680, Ext. 4583