



To: BJWSA  
Cross-Connection Control

Date:

TEST SUBMITTAL FAX: 843-548-4171

TEST SUBMITTAL EMAIL: [Backflowprevention@bjwsa.org](mailto:Backflowprevention@bjwsa.org)

Attn:

From: Company Name:

Contact Name:

Phone#:

Fax#:

Email Address:

Tests must be submitted within two (2) business days of a failed test or ten (10) business days of a passing test. All forms submitted must be filled out accurately and completely. Testers not on the approved tester list or in compliance with the BJWSA Program cannot perform tests. Tests will be reviewed and entered within 48 hours of receipt. There is no reason to call for verification until after that time period. If tests are not acceptable, you will be contacted by the backflow coordinator. Enter an identifying mark (Device S/N, Device number, or Account number) for each test being transmitted. Make every attempt to keep tests in order of list. Fax is limited to 30 sheets. For submittals for more than 29 tests, break submittal into two transmittals. On accounts with multiple assemblies, each assembly should have a line ... one line for each test! One test submittal sheet per tester.

- |          |          |          |
|----------|----------|----------|
| 1 _____  | 11 _____ | 21 _____ |
| 2 _____  | 12 _____ | 22 _____ |
| 3 _____  | 13 _____ | 23 _____ |
| 4 _____  | 14 _____ | 24 _____ |
| 5 _____  | 15 _____ | 25 _____ |
| 6 _____  | 16 _____ | 26 _____ |
| 7 _____  | 17 _____ | 27 _____ |
| 8 _____  | 18 _____ | 28 _____ |
| 9 _____  | 19 _____ | 29 _____ |
| 10 _____ | 20 _____ |          |

Comments:



For questions relating to this form, contact:  
 BackflowPrevention@bjwsa.org  
 Phone: 843.987.8068 Fax: 843.548.4171

**Backflow ID / Device No.:** \_\_\_\_\_

**Passed**  **Y**  **N**

**Date:** \_\_\_\_\_

Account Name / Business: \_\_\_\_\_

Account Address: \_\_\_\_\_

Customer Number: \_\_\_\_\_ Account Number: \_\_\_\_\_ Service Type: \_\_\_\_\_

Device Mfg: \_\_\_\_\_ Model Name: \_\_\_\_\_ Installed: \_\_\_\_\_

Serial Number: \_\_\_\_\_ Size: \_\_\_\_\_ Device Type: \_\_\_\_\_

Device Location: \_\_\_\_\_

Tested By (Print): \_\_\_\_\_

	Check No.1	Check No.2	Differential Pressure Relief Valve	#1 Gate or Ball (Circle One)	#2 Gate or Ball (Circle One)
Test Before Repairs	(Mark One)	(Mark One)	Opened at _____ lbs. Differential Pressure	(Mark One)	(Mark One)
	Leaked _____ Closed Tight _____	Leaked _____ Closed Tight _____		Leaked _____ Closed Tight _____	Leaked _____ Closed Tight _____
	Drop Across _____	Drop Across _____			
Repairs And New Materials					
Test After Repairs	(Mark One)	(Mark One)	Opened at _____ lbs. Differential Pressure	(Mark One)	(Mark One)
	Leaked _____ Closed Tight _____	Leaked _____ Closed Tight _____		Leaked _____ Closed Tight _____	Leaked _____ Closed Tight _____
	Drop Across _____	Drop Across _____			

Above date certified to be correct.

Testers Signature: \_\_\_\_\_ Certification Number: \_\_\_\_\_

Company Name: \_\_\_\_\_ Company Telephone Number: \_\_\_\_\_

Category: \_\_\_\_\_ General: \_\_\_\_\_ Limited: \_\_\_\_\_ Inspector Tester: \_\_\_\_\_

Method of Testing: \_\_\_\_\_ Test Kit Used: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_