



RETURN THIS TEST FORM TO:

**Illinois American Water**

Email: [ilaw.crossconnection@amwater.com](mailto:ilaw.crossconnection@amwater.com)

Mail to: ILAW Cross Connection Department, 4436 Industrial Drive, Alton, IL 62002

Contact Phone: 800-262-9440 Fax: 618-466-9422

Account No: \_\_\_\_\_

Premise No. \_\_\_\_\_

**LOCATION INFORMATION**

Service For: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

Type of Service: Domestic  Fire  Irrigation

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

New Assembly  Replaces Serial No: \_\_\_\_\_

**DEVICE INFORMATION**

Type of Assembly: \_\_\_\_\_

Serial No: \_\_\_\_\_ Size: \_\_\_\_\_

Mfn/Model No: \_\_\_\_\_

Water Meter No: \_\_\_\_\_

Isolation  Containment

**TEST MEASUREMENTS**

Evaluation	DC		RP
	Check Valve #1	Check Valve #2	Differential Relief Valve
<b>Initial</b> Date: _____ Time: _____ Line pressure: ____	Held at ____ PSID  Closed Tight <input type="checkbox"/> Leaked <input type="checkbox"/>	Held at ____ PSID  Closed Tight <input type="checkbox"/> Leaked <input type="checkbox"/>  <b>#2 Shut Off Valve</b> Closed Tight? Yes <input type="checkbox"/> No <input type="checkbox"/>	Opened at ____ PSID  Did Not Open <input type="checkbox"/>
<b>Final</b> Date: _____ Time: _____ Line pressure: ____	Held at ____ PSID  Closed Tight <input type="checkbox"/> Leaked <input type="checkbox"/>	Held at ____ PSID  Closed Tight <input type="checkbox"/> Leaked <input type="checkbox"/>  <b>#2 Shut Off Valve</b> Closed Tight? Yes <input type="checkbox"/> No <input type="checkbox"/>	Opened at ____ PSID  Did Not Open <input type="checkbox"/>

MAINTENANCE SERVICE PERFORMED – Cleaned = C; Repaired = R

Valve	Rubber Kit	Seat	Seat O-Ring Assembly	Spring	Disk	Nuts / Washers	Other (provide comments below)
<b>Other Comments:</b>							

AIR GAP: Measured vertical inches above overflow rim: \_\_\_\_\_ Supply size diameter: \_\_\_\_\_

COMMENTS:

**TESTER INFORMATION**

<b>INITIAL</b>	Tester Name: _____	Company: _____
	Signature: _____	CCCDI Number.: _____
	Testing Equipment Calibration Date: _____	<b>PASS</b>
	Testing Equipment Serial Number: _____	<b>FAIL</b>
<b>FINAL</b>	Tester Name: _____	Company: _____
	Signature: _____	CCCDI Number.: _____
	Testing Equipment Calibration Date: _____	<b>PASS</b>
	Testing Equipment Serial Number: _____	<b>FAIL</b>

BACKFLOW TEST FROM – TO BE COMPLETED BY A QUALIFIED TESTER

The above report is certified to be true at the time of the test.