CITY OF EAST PROVIDENCE
WATER UTILITIES DIVISION
60 Commercial Way, East Providence, RI 02914
Phone: 401-435-7741 FAX: 401-435-7745

Backflow Prevention Device Design Data Sheet

I. OWNER

OWNER'S NAME: _____

ADDRESS: _____

II. FACILITY

NAME: _____ ADDRESS: _____

CONTACT PERSON: _____

TELEPHONE NUMBER OF FACILITY CONTACT PERSON: _____

SERVICE METER NUMBER:_____

CHECK ALL THAT APPLY:

NEW FACILITY ☐ EXISTING FACILITY ☐ PROPERTY REHAB ☐

DOMESTIC SERVICE ☐ FIRE SERVICE ☐ LAWN IRRIGATION ☐

DESCRIPTION OF BUSINESS ACTIVITIES AT THIS FACILITY:

_____

_____

III. DEVICE DATA

TYPE: _____ MANUFACTURER: _____ MODEL NO. : _____

SIZE: _____ HOT OR COLD WATER UNIT: _____

LOCATION OF DEVICE (BE SPECIFIC): _____

BYPASS ARRANGEMENT? : _____ TYPE OF SHUT-OFF VALVE: _____

UL OR FM APPROVAL? : _____

FROM WHAT TYPE OF CONTAMINATION IS THE WATER SUPPLY PROTECTED?:

_____

_____

NUMBER OF OTHER DEVICES LOCATED AT THIS FACILITY: _____

IV. PIPING SCHEMATICS REQUIRED

A FULLY LABELED, DETAILED SCHEMATIC OF THE POTABLE AND NON-POTABLE WATER PIPING IMMEDIATELY SURROUNDING THE BACKFLOW PREVENTION DEVICE INSTALLATION SHOWING THE FOLLOWING:

- HEIGHT ABOVE THE FINISHED FLOOR.
- DISTANCE FROM WALLS(S).

(SEE NEXT PAGE)

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- TYPE OF EQUIPMENT OR SYSTEM(S) DOWNSTREAM OF (AFTER) THE BACKFLOW PREVENTION DEVICE. (CHEMICAL TREATMENT, OPERATING PRESSURE, ETC.)
- MANUFACTURER, MAKE, MODEL, SIZE AND ALIGNMENT OF THE BACKFLOW PREVENTION DEVICE.
- LOCATION OF UPSTREAM AND DOWNSTREAM SHUT-OFF VALVES & WYE STRAINER.
- ANY ADDITIONAL INFORMATION PARTICULAR TO THE BACKFLOW PREVENTION DEVICE INSTALLATION THAT SHOULD BE REVIEWED.

*****PLEASE NOTE THAT THE PIPING SCHEMATIC MUST BE AT LEAST 8 ½" X11 ½" WITH A COMPLETED TITLE BLOCK (NAME OF FACILITY, ADDRESS, DATE, PREPARER, SCALE, ETC.).*****

V. INSTALLATION AND TESTING SCHEDULE

INSTALLER'S NAME: _____

MASTER PLUMBER'S LICENSE/FIRE SPRINKLER NO. (PLEASE INDICATE) _____

COMPANY NAME: _____ PHONE NO.: _____

ESTIMATED DATE OF COMPLETION: _____

TESTER'S NAME: _____ TESTER'S CERTIFICATE NO.: _____

TESTER'S CONTACT INFORMATION: _____

MINIMUM TESTING REQUIRED: IMMEDIATELY AFTER INSTALLATION AND ANNUALLY THEREAFTER EXCEPT FOR RESIDENTIAL DUAL CHECK DEVICES.

EACH DEVICE REQUIRES AN INDIVIDUAL FORM, INCOMPLETE FORMS WILL NOT BE ACCEPTED

_____ _____ _____

Authorized Signature Printed Name Date

For Departmental use only:

Notes:

☐ APPROVED ☐ NOT APPROVED

_____ _____

Reviewer's Signature Date