BACKFLOW TESTER INFORMATION

TESTER NAME: _____

COMPANY: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: _____ **CELL:** _____

E-MAIL: _____

FAX: _____

CERTIFIED FOR:

- ☐ **INSTALLATIONS**
- ☐ **TEST**
- ☐ **SURVEYS**
- ☐ **REPAIRS**

CERTIFICATION #: _____

CERTIFICATION DATE: _____

EXPIRATION DATE: _____

Please enclose copies of all certifications you have obtained.

Return completed document and certifications to:

City of Salina
Utilities Department
Attn: Water Quality Coordinator
300 W. Ash, Room 205
P.O. Box 736
Salina, KS 67402-0736

E-mail: backflow@salina.org
Fax: 785-309-5713