



San Francisco City and County
Department of Public Health
Environmental Health Branch
Cross Connection Control Program

APPLICATION FOR CERTIFIED BACKFLOW ASSEMBLY TESTER
PERMIT TO OPERATE

Please Print	Application Date:
NAME OF TESTER:	TESTER'S SIGNATURE:
DBA:	TELEPHONE NUMBER:
ADDRESS:	
CITY, STATE, ZIP CODE:	
INSURANCE COMPANY:	TELEPHONE NUMBER:
ADDRESS:	CITY, STATE, ZIP CODE:
POLICY NUMBER:	POLICY EFFECTIVE DATE:

===== **FOR DEPARTMENT OF PUBLIC HEALTH OFFICE USE ONLY** =====

AWWA/ASSE Certificate #:	Certificate Expiration Date:
Application Fee:	Exam Fee:
Exam Date:	Exam Score:

To the Director of Public Health:

After careful review of the above application on _____, 20_____

_____ I **RECOMMEND** the issuance of a Backflow Device Tester Permit To Operate

_____ I **DISAPPROVE** the issuance of the Permit To Operate for the following reasons:

Inspector: _____ Application Taken By: _____

Principal Inspector: _____ Processed By: _____

PERMIT TO OPERATE #: _____ **Tax Collector Account Number:** _____