



City and County of San Francisco  
 DEPARTMENT OF PUBLIC HEALTH  
 ENVIRONMENTAL HEALTH

APPLICATION FOR AUTHORIZED BACKFLOW ASSEMBLY TESTER PERMIT TO OPERATE

1. Tester Information	
Tester Name	Cell Phone
Home Address (Street, city, state, zip code)	Alternate Phone Number
Email Address (For correspondence and <b>CCAMS database access</b> )	Personal/Alternate Email Address

2. Company Information (If approved, company contact information will be posted on the SFDPH website)	
Business Name	Main Business Phone
Business Address (Street, city, state, zip code)	
Email Address	Website

3. Insurance Information			
Insurance Company	Commercial Liability Policy #	Effective Date	Expiration Date

4. Backflow Prevention Assembly Tester Certification			
<input type="checkbox"/> AWWA <input type="checkbox"/> ABPA <input type="checkbox"/> NCBPA <input type="checkbox"/> ASSE	Certificate #	Issue Date	Expiration Date

5. Test Equipment			
Serial #	Model #	Calibration Company	Expiration Date

6. Terms and Conditions			
Do you acknowledge that the following items must be submitted with this application? (Mark "Yes" to confirm)			<b>SFDPH OFFICE USE ONLY</b>
Yes	N/A		
<input type="checkbox"/>	<input type="checkbox"/>	Certificate of Liability Insurance for Commercial General Liability	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Backflow Tester Certification	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Test Equipment Calibration Certificate	<input type="checkbox"/>

I agree to operate in accordance with all applicable federal, state, and local regulations, laws, and ordinances. I understand that this application is subject to review by the San Francisco Department of Public Health, Environmental Health Branch ("SFDPH, EHB"). I declare under penalty of perjury that the information in this application and materials submitted in support of this application are true and complete to the best of my knowledge and belief. If my permit application is approved, I understand that I must follow the requirements set forth in Article 12A of the San Francisco Health Code to maintain a valid permit, and I will notify EHB of changes to the above information and when I cease testing operations.

Tester Signature **x** \_\_\_\_\_ Date \_\_\_\_\_

For Department of Public Health Office Use Only					
Payment Date	App Fee \$	Exam Fee \$	Total Paid \$	Check #	Receipt #
Exam Score	Conditions/Notes:				
To the Director of Public Health, after reviewing this application on _____, 20_____, <input type="checkbox"/> I <b>recommend</b> the issuance of a Permit to Operate. <input type="checkbox"/> I <b>disapprove</b> the issuance of a Permit to Operate for the following reasons:					
X _____	Inspector		X _____	Manager	
Permit #	Classification		BAN	Permit Activation Date	

Revised: 8/2020 MAK