



Backflow Prevention for Severe Health Hazard Facility

Annual Summary Report Year: _____

PWS ID:	PWS Name:	County:
----------------	------------------	----------------

Backflow Protection Status

Describe the backflow protection status at the end of report year for each *wastewater treatment plant and nuclear facility* your system serves. Attach more sheets if needed.

None served

Facility Name, Physical Address, And NPDES Permit Number ¹	Status of Backflow Protection at end of 2011 (check one box per row)							
	Premises Isolation RP and In-plant Air Gap(s) ²	Premises Isolation RP but No In-Plant Air Gap(s)	Premises Isolation Air Gap	Fixture Protection Only	No Protection At All	Unknown	Exception Granted	Other (explain in Comment Section on page 2)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NPDES Permit #:								
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NPDES Permit #:								
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NPDES Permit #:								
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NPDES Permit #:								

¹NPDES Permit Number applies to wastewater treatment facilities only. Please request from the facility being served.

²For wastewater treatment plants and nuclear facilities, air gaps(s) must be provided on potable water lines supplying process water (seal water, plant washdown water, flushing, etc.)

Comments and Clarifications

Enter comments about the information provided on page 1.

Facility Name (from page 1)	Comment

Completion Information

Enter dates in MM/DD/YYYY format.

I certify that the information provided in this questionnaire is complete and accurate to the best of my knowledge.		
CCC Program Mgr. Name (Print) ¹ :	Title:	
Signature:	Date:	
Phone: (____) ____-____	E-mail: _____@_____	
I certify that the information provided in this questionnaire accurately describes the status of backflow protection at the severe hazard facilities served by our system.		
PWS Manager/Owner Name (Print) ² :	Title:	
Signature:	Op. Cert No:	Date:

¹ The CCC Program Manager is generally the CCS responsible for developing and implementing the PWS’s CCC program.

² The person that the CCC Program Manager reports to or other manager having direct responsibility and/or oversight of the CCC program. This person doesn’t need to be in charge of the entire water system.

If you have a question or comment regarding this form, you can find contact information at <https://www.doh.wa.gov/communityandenvironment/drinkingwater> or email us at CCCprogram@doh.wa.gov.

If you need this publication in an alternate format, call (800) 525-0127. For TTY/TDD, call (800) 833-6388.