CROSS CONNECTION HAZARD ASSESSMENT REPORT

FACILITY NAME: ____ **DATE:** __________________ **TIME:** _________

FACILITY ADDRESS: ____

MAILING ADDRESS: ____

CONTACT PERSON: ____ **TELEPHONE:** ________________________

FACILITY TYPE: _____________________________ **Containment** ( ) **Isolation** ( ) **Hazard Priority:** High ( ) Medium ( ) Low ( )

LOCATION OF CROSS CONNECTION			**DEGREE OF HAZARD**		Health Non Health
TYPE OF CROSS CONNECTION					
RECOMMENDED CORRECTIVE ACTIONS AND COMMENTS					
TIME TO COMPLETE		**DATE COMPLETED**		**BACKFLOW PREVENTION TYPE**	AG RP DC PVB SVB AVB HBVB

LOCATION OF CROSS CONNECTION			**DEGREE OF HAZARD**		Health Non Health
TYPE OF CROSS CONNECTION					
RECOMMENDED CORRECTIVE ACTIONS AND COMMENTS					
TIME TO COMPLETE		**DATE COMPLETED**		**BACKFLOW PREVENTION TYPE**	AG RP DC PVB SVB AVB HBVB

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WATER SYSTEM

Inspector: ____

Phone Number: ____

FACILITY REPRESENTATIVE

Signature: ____

Print Name: ____