

BACKFLOW ASSEMBLY TESTER RECERTIFICATION

Date: _____

Tester's Name: _____

Company Name: _____

Mailing Address: _____

City State Zip

SC DHEC Certification Number
<i>List all of your current certification numbers</i>
General: _____
Limited: _____
Inspector: _____

Tester's Phone Numbers:

Business Phone: _____

Cellular: _____

Fax: _____

Email: _____

Dates Not Available for Clinics:
Note: Clinic Days Typically Tuesday - Thursday

Do you accept text messages? YES NO

Does the applicant hold more than one certification? YES NO

Does the applicant own or use more than one test kit? YES NO

Type of Test Kit: 3 VALVE 5 VALVE

SEND FORM AND PAYMENT TO ADDRESS

Inman-Campobello Water District (ICWD)
 Attn: October Ivester
 5 Prospect Street,
 Inman, SC 29349

Email: October@icwd.org
 Phone: (864) 806-9108
 Fax: (864) 472-6812



THIS APPLICATION FORM IS YOUR INVOICE

Recertification Fee: \$60.00
 Administrative Charge: \$35.00

Payment Due: \$95.00

Payment Received: _____

SELECT PRE-PAYMENT METHOD
(NO REFUNDS for Failure to Attend Clinic)

CASH
 CHECK
 CREDIT CARD AT CLINIC