|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Place  Logo  Here | Place Your Name Here | | | | | **TYPE OF SAMPLE** (select only **one** type of sample from types 1 through 5 below) | | | |
| **COLIFORM BACTERIA ANALYSIS** | | | | | 1.  **Routine Distribution Sample (A/P)**  Chlorinated: Yes\_\_\_\_\_\_ No\_\_\_\_\_\_  Chlorine Residual: Total\_\_\_\_ Free\_\_\_\_ | 2.  **Repeat Sample (A/P)**  (from distribution system after unsat. routine)  Unsatisfactory routine lab number:  \_\_\_\_ \_\_\_\_ \_\_\_\_ - \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_  Unsatisfactory routine collect date:  \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_  Chlorinated: Yes\_\_\_\_\_\_ No\_\_\_\_\_\_  Chlorine Residual: Total\_\_\_\_\_ Free\_\_\_\_\_ | | |
| Send results to: (Print full name, address and zip code)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOH Form #331-320 (effective 6/17)  If you need this publication in an alternative format, call 800.525.0127 (TDD/TTY call 711). This and other publications are available at [www.doh.wa.gov/drinkingwater](http://www.doh.wa.gov/drinkingwater). | Date Sample Collected  **/ /**  Month Day Year | Time Sample  Collected  AM  \_\_\_\_\_ : \_\_\_\_\_  PM | | County | |
| 3. **Ground Water Rule Source Sample**   |  |  |  | | --- | --- | --- | | **S** |  |  |   Triggered (A/P)  Assessment (A/P) |
| Type of Water System (check only one box)  Group A  Group B  Other\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Group A and Group B System  ID # \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ | | | | |
| System Name: | | | | | |  |  |  | | --- | --- | --- | | **S** |  |  |   4. **Surface or GWI Raw Source Water Sample** (Enumeration)  *E. coli*  Fecal Filtered Yes\_\_\_\_\_ No\_\_\_\_\_ | | | |
| Contact Person: | | | | | 5. Sample Collected for **Information Only** | | | |
| Day Phone: ( ) | | Cell Phone: ( ) | | | LAB USE ONLY **DRINKING WATER RESULTS** LAB USE ONLY | | | |
| Eve. Phone: ( ) | | FAX: ( ) | | | **Unsatisfactory** Total Coliform Present **and**  *E.coli* present  *E.coli* absent | | | **Satisfactory** |
| **SAMPLE INFORMATION** | | | | |
| Sample collected by (name): | | | | | **Bacterial Density Results**: Total Coliform\_\_\_\_\_\_\_\_\_\_\_\_/100ml. *E.coli*\_\_\_\_\_\_\_\_\_\_\_\_/100ml.  Fecal Coliform\_\_\_\_\_\_\_\_\_\_\_\_\_\_/100ml. HPC\_\_\_\_\_\_\_\_\_\_\_\_\_\_/1ml. | | | |
| Specific location where sample collected: | | Special instructions or comments: | | |
| **Replacement Sample Required:**   TNTC  Sample too old  Sample Volume  Damaged Container  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Date/Time Received: | | Lab Reference Number | |
| Receipt Temp C°: | | Method Code: | |
| Date Reported to DOH: | | Lab Use Only: | |
|  | DOH Lab-Sample # | |
|  |  | | | | |  | |  | |
|  |  | | | | |  | |  | |
| Place  Logo  Here | Place Your Name Here | | | | | **TYPE OF SAMPLE** (select only **one** type of sample from types 1 through 5 below) | | | |
| **COLIFORM BACTERIA ANALYSIS** | | | | | 1.  **Routine Distribution Sample (A/P)**  Chlorinated: Yes\_\_\_\_\_\_ No\_\_\_\_\_\_  Chlorine Residual: Total\_\_\_\_ Free\_\_\_\_ | 2.  **Repeat Sample (A/P)**  (from distribution system after unsat. routine)  Unsatisfactory routine lab number:  \_\_\_\_ \_\_\_\_ \_\_\_\_ - \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_  Unsatisfactory routine collect date:  \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_  Chlorinated: Yes\_\_\_\_\_\_ No\_\_\_\_\_\_  Chlorine Residual: Total\_\_\_\_\_ Free\_\_\_\_\_ | | |
| Send results to: (Print full name, address and zip code)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOH Form #331-320 (effective 6/17)  If you need this publication in an alternative format, call 800.525.0127 (TDD/TTY call 711). This and other publications are available at [www.doh.wa.gov/drinkingwater](http://www.doh.wa.gov/drinkingwater). | Date Sample Collected  **/ /**  Month Day Year | Time Sample  Collected  AM  \_\_\_\_\_ : \_\_\_\_\_  PM | | | County |
| 3. **Ground Water Rule Source Sample**   |  |  |  | | --- | --- | --- | | **S** |  |  |   Triggered (A/P)  Assessment (A/P) |
| Type of Water System (check only one box)  Group A  Group B  Other\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Group A and Group B System ID#  ID# \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ | | | | |
| System Name: | | | | | |  |  |  | | --- | --- | --- | | **S** |  |  |   4. **Surface or GWI Raw Source Water Sample** (Enumeration)  *E. coli*  Fecal Filtered Yes\_\_\_\_\_ No\_\_\_\_\_\_\_ | | | |
| Contact Person: | | | | | 5. Sample Collected for **Information Only** | | | |
| Day Phone: ( ) | | Cell Phone: ( ) | | | LAB USE ONLY **DRINKING WATER RESULTS** LAB USE ONLY | | | |
| Eve. Phone: ( ) | | FAX: ( ) | | | **Unsatisfactory** Total Coliform Present **and**  *E.coli* present  *E.coli* absent | | | **Satisfactory** |
| **SAMPLE INFORMATION** | | | | |
| Sample collected by (name): | | | | | **Bacterial Density Results**: Total Coliform\_\_\_\_\_\_\_\_\_\_\_\_/100ml. *E.coli*\_\_\_\_\_\_\_\_\_\_\_\_/100ml.  Fecal Coliform\_\_\_\_\_\_\_\_\_\_\_\_\_\_/100ml. HPC\_\_\_\_\_\_\_\_\_\_\_\_\_\_/1ml. | | | |
| Specific location where sample collected: | | Special instructions or comments: | | |
| **Replacement Sample Required:**  TNTC  Sample too old  Sample Volume  Damaged Container  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Date/Time Received: | | Lab Reference Number | |
| Receipt Temp C°: | | Method Code: | |
| Date Reported to DOH: | | Lab Use Only: | |
|  | DOH Lab-Sample # | |