

STATE OF WASHINGTON WATER BACTERIOLOGICAL ANALYSIS

| | | |
|-----------------------|---|-------------|
| DATE COLLECTED / / | TIME COLLECTED : <input type="checkbox"/> AM <input type="checkbox"/> PM | COUNTY NAME |
|-----------------------|---|-------------|

| | |
|--|---|
| TYPE OF SYSTEM <input type="checkbox"/> PUBLIC <input type="checkbox"/> INDIVIDUAL <small>(serves only 1 residence)</small> | IF PUBLIC SYSTEM, COMPLETE: I.D. No. A <input type="checkbox"/> B <input type="checkbox"/> GROUP |
| NAME OF SYSTEM | |

| | |
|--|--|
| SPECIFIC LOCATION WHERE SAMPLE COLLECTED | TELEPHONE NO. DAY EVENING (SAME) |
|--|--|

| | |
|-----------------------------|---------------------------|
| SAMPLE COLLECTED BY: (Name) | SYSTEM OWNER/MGR.: (Name) |
|-----------------------------|---------------------------|

SOURCE TYPE GROUND WATER UNDER SURFACE INFLUENCE
 SURFACE WELL or WELL FIELD SPRING
 PURCHASED or INTERTIE COMBINATION OR OTHER

SEND REPORT TO: (Print Full Name, Address, and Zip Code)

| | | | |
|---|--|-------|--|
| TYPE OF SAMPLE (Check only one in this column) | | | |
| <input type="checkbox"/> ROUTINE DRINKING WATER check treatment | <input type="checkbox"/> Chlorinated (Residual): <input type="checkbox"/> Filtered <input type="checkbox"/> Untreated or Other | Total | Free |
| <input type="checkbox"/> REPEAT SAMPLE | Previous Coliform presence | Lab# | Date / / |
| <input type="checkbox"/> RAW SOURCE WATER | Source# | S | <input type="checkbox"/> Total Coliform <input type="checkbox"/> Fecal Coliform |
| <input type="checkbox"/> NEW CONSTRUCTION or REPAIRS | | | |
| <input type="checkbox"/> OTHER (Specify) | | | |

REMARKS:

| (LAB USE ONLY) DRINKING WATER RESULTS | |
|---|--|
| <input type="checkbox"/> UNSATISFACTORY, Coliforms present | <input type="checkbox"/> SATISFACTORY Coliforms Absent |
| REPEAT SAMPLES <input type="checkbox"/> Total Present <input type="checkbox"/> Total Absent | |
| REQUIRED <input type="checkbox"/> E. Coli Present <input type="checkbox"/> E. Coli Absent | |

(LAB USE ONLY) TEST SETUP INFORMATION

Date/Time/Tech. Sample into Incubator:

Date/Time/Tech. Sample out of Incubator:

Media used:

| | | |
|----------------------------------|---------------------|--------------|
| LAB NO. (8 DIGITS) 021 | DATE, TIME RECEIVED | RECEIVED BY |
| DATE REPORTED | TECHNICIAN | Approved by: |



Accurate Testing Labs LLC
 7950 Meadowlark Way, Coeur d'Alene, ID 83814
 Phone: (208) 762 8378 Fax: (208) 762 9082
 www accuratetesting.com

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