

DRAFT

**CONCEPT EXAMPLE
LEVEL 1 ASSESSMENT FORM**

System Name:	Source Water:	PWSID #
System Type:	System Size:	
Operator in Responsible Charge (ORC):	Phone:	PWS Address:
City, State:		
County:		
Person that collected TC samples if different than ORC:	Phone:	
Address, City, State, Zip:		
Date Assessment Completed:		

	Questions	Review	Applicable	Issue Identified	Issue Description	Corrective Action Taken (Including Date)
M A N A G E M E N T	1. Have any of the following occurred at relevant facilities prior to the collection of TC samples?	<input type="checkbox"/>	Y N	Y N		
	(Any interruptions in the treatment process; any reported loss of pressure events (5 psi); operation and maintenance activities that could have introduced total coliform; reported vandalism and/or unauthorized access to facilities; visible indicators of unsanitary conditions reported; Has there been a fire fighting event, flushing operation, sheared hydrant, etc.)					
	2. Have there been any recent changes?	<input type="checkbox"/>	Y N	Y N		
	(Sources introduced, treatment or operational changes, potential sources of contamination)					
	3. Evaluate sample site.	<input type="checkbox"/>		Y N		
	(Condition or location of tap, regular use of connection)					
	4. Sample protocol followed. And reviewed	<input type="checkbox"/>		Y N		
	(Flush tap, remove aerator, no swivel, fresh sample bottles, sample storage acceptable)					

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Questions	Review	Applicable	Issue Identified	Issue Description	Corrective Action Taken (Including Date)
5. Distribution System.	<input type="checkbox"/>	Y N	Y N		
(System pressure, cross connection, pump station, air relief valves, fire hydrants or blow off, breaks, repairs)					
6. Storage Tank.	<input type="checkbox"/>	Y N	Y N		
(Screens, security, access opening, condition of tank, vent, drain overflow, pressure tank, O&M)					
7. Treatment Process. (If applicable)	<input type="checkbox"/>	Y N	Y N		
(Interruptions, POE/POU, softeners, O&M)					
8. Source - Well	<input type="checkbox"/>	Y N	Y N		
(Sanitary seal, vent screened, air gap, cross connection, security, pump to waste line)					
9. Source - Spring	<input type="checkbox"/>	Y N	Y N		
(Condition of spring development, condition of spring box, security)					
10. Source - Surface Water Supply		Y N	Y N		
(Heavy Rainfall, rapid snowmelt, flooding, changes in availability, power outages)					

Print name of person completing form: _____ Date: _____

Signature: _____

Reserved for State

- 1 Assessment has been successfully completed.
- 2 Likely reason of total coliform positives occurred is established and the system
- 3 Was a Reset Requested and/or Granted - Rationale
- 4 Name of State Reviewer:

Note: Form to be completed based on data and documents available to the PWS operator in charge, maintained on file and returned to the Primacy Agency within XX days.