



Anatek Labs, Inc.
 504 E. Sprague Suite D
 Spokane, WA 99202
 509-838-3999

COLIFORM BACTERIA ANALYSIS

| | | |
|--|---------------------------------------|--------|
| Date Sample Collected / / Month Day Year | Time Sample Collected : : AM PM | County |
|--|---------------------------------------|--------|

Type of Water System (check only one box)
 Group A Group B Other _____

Group A and Group B Systems – Provide from Water Facilities Inventory (WFI):
 ID# _____
 System Name: _____

Contact Person: _____
 Day Phone: () Cell Phone: ()
 Eve. Phone: () FAX: ()

Send results to: (Print full name, address and zip code)

SAMPLE INFORMATION

Sample collected by (name): _____
 Specific location where sample collected: _____
 Special instructions or comments: _____

Type of Sample (must check only one box of #1 through #4 listed below)

| | |
|--|---|
| <p>1. Routine Distribution Sample Chlorinated: Yes _____ No _____ Chlorine Residual: Total _____ Free _____</p> | <p>2. Repeat Sample (after unsat. routine) <input type="checkbox"/> Distribution System <input type="checkbox"/> Source Groundwater Rule (GWR) (Population of 1,000 or less) Unsatisfactory routine lab number: _____ - _____ Unsatisfactory routine collect date: ____/____/____ Chlorinated: Yes _____ No _____ Chlorine Residual: Total _____ Free _____</p> |
| <p>3. Raw Water Source Sample <input type="checkbox"/> <i>E. coli</i> – GWR source sample <input type="checkbox"/> Fecal –Surface, GWI, some springs <input type="checkbox"/> Other _____ _____ _____ Public systems must provide source number from WFI</p> | |

4. Sample Collected for Information Only
 Investigative _____ Construction / Repairs _____ Other _____

LAB USE ONLY **DRINKING WATER RESULTS** LAB USE ONLY

| | |
|---|--|
| <input type="checkbox"/> Unsatisfactory Total Coliform Present and <input type="checkbox"/> <i>E. coli</i> present <input type="checkbox"/> <i>E. coli</i> absent <input type="checkbox"/> Fecal coliform present <input type="checkbox"/> Fecal coliform absent | <input type="checkbox"/> Satisfactory |
|---|--|

Replacement Sample Required:
 Sample too old (>30 hours) TNTC _____
 Improper Container Turbid culture

Bacterial Density Results: Plate Count _____/ml. *E. coli* _____/100ml.
 Total Coliform _____/100ml. Fecal Coliform _____/100ml.

Method Code: _____ Date and Time Received: _____
MICR- _____

Date Analyzed: _____ Date Reported: _____
 Sample Number (DOH number plus five digits) _____ Lab Use Only: _____