

**DRAGON Analytical Laboratory**

627 Durrell RD SE, Ste. B105  
 Tumwater, WA 98501  
 Phone: (360) 866-0543 | Fax: (360) 866-0556  
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**COLIFORM BACTERIA ANALYSIS FORM**

Date Sample Collected / / Month Day Year	Time Sample Collected : : AM PM	County
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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: (    )  
 Email: \_\_\_\_\_    Eve. Phone: (    )

Send results to: (Print full name, address and zip code or e-mail)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SAMPLE INFORMATION**

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

**Type of Sample** (select only one type of sample from types 1 through 5 below)

<b>1. Routine Distribution Sample (A/P)</b> Chlorinated: Yes _____ No _____ Chlorine Residual: Total _____ Free _____	<b>2. Repeat Sample (A/P)</b> (from distribution system after unsat. routine) Unsatisfactory routine lab number: _____ Unsatisfactory routine collect date: _____/_____/_____ Chlorinated: Yes _____ No _____ Chlorine Residual: Total _____ Free _____				
<b>3. Ground Water Rule Source Sample</b> <table border="1"> <tr><td>S</td><td></td><td></td><td></td></tr> </table> <input type="checkbox"/> Triggered (A/P) <input type="checkbox"/> Assessment (A/P)	S				Unsatisfactory routine collect date: _____/_____/_____ Chlorinated: Yes _____ No _____ Chlorine Residual: Total _____ Free _____
S					

**4. Surface or GWI Raw Source Water Sample** (Enumeration) 

S			
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 *E. coli*     Fecal    Filtered Yes \_\_\_\_\_ No \_\_\_\_\_

5.  Sample Collected for Information Only:

**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"/> Satisfactory
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**Replacement Sample Required:**  
 Sample too old (>30 hours)     TNTC     \_\_\_\_\_

Bacterial Density Results: Total Coliform \_\_\_\_\_/100ml. *E. coli* \_\_\_\_\_/100ml.  
 Fecal Coliform \_\_\_\_\_/100ml. HPC \_\_\_\_\_/1 ml.

Date/Time Received:	Lab Reference Number
Date/Time In Incubator:	Method Code:
Date/Time Out Incubator:	Receipt Temp C°:
DOH Lab-Sample#	Lab Use Only:

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Date/Time In Incubator:	Method Code:
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DOH Lab-Sample#	Lab Use Only: