

AVOCET

ENVIRONMENTAL TESTING

1500 NORTH STATE STREET BELLINGHAM, WA 98225 (360) 734-9033

Date Sample Collected 3113113 <small>Month Day Year</small>	Time Sample Collected _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	County ISLAND
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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# 39850R

System Name:
HONEYMOON BAY HEIGHTS

Contact Person: BOB DUFFY

Day Phone: (360) 331-6311 Cell Phone: (360) 929-3027

Eve. Phone: (360) 331-6311 FAX: (360) 331-6299

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

BOB DUFFY
PO BOX 223
FIRELAND WA 98249

SAMPLE INFORMATION

Sample collected by (name):
BOB DUFFY

Specific location where sample collected: DOWNSTAIRS BATH	Special instructions or comments:
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Type of Sample (must check only one box of #1 through #4 listed below)

1. <input checked="" type="checkbox"/> Routine Distribution Sample Chlorinated: Yes _____ No <input checked="" type="checkbox"/> Chlorine Residual: Total _____ Free _____	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 _____
3. Raw Water Source Sample <input type="checkbox"/> E. coli - GWR source sample <input type="checkbox"/> Fecal - Surface, GWI, some springs <input type="checkbox"/> Other <div style="border: 1px solid black; display: inline-block; padding: 2px;">S</div> Public systems must provide source number from WFI	

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"/> E. coli present <input type="checkbox"/> E. coli 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: MICR- <u>2</u> <u>7</u> <u>2</u> <u>0</u>	Date and Time Received:
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Date Analyzed:	Date Reported:
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Sample Number (DOH number plus five digits) 057	Lab Use Only:
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DOH Form #331-319 (revised 11/10)

B 17863

COLIFORM BACTERIA ANALYSIS
DP CENTER COPY

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