



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Revised Total Coliform Rule Level 1 Assessment Form

PWS ID#:	PWS Name:	Town:
System Type: CWS NTNC TNC	Date Assessment Form Completed: <i>This form must be completed and returned no later than 30 days after the Assessment Trigger Date.</i>	
Assessment Trigger Date:		
Assessment Trigger:	For a system collecting at least 40 samples per month, more than 5.0% of samples collected are TC+ For a system collecting fewer than 40 samples per month, two or more samples are TC+ The PWS fails to take every required repeat sample after any single routine TC+	

NOTE: If this is the second Level 1 treatment technique trigger within the past 12-month rolling period, the system is required to perform a Level 2 Assessment.

Instructions: Review and evaluate all of the elements for possible sanitary defects. Indicate Yes or No if any sanitary defects are identified or N/A if the element is not applicable to the water system. **All sections of this form must be completed.** If a sanitary defect is identified, provide a description of the defect along with the actions taken or proposed to correct the defect. Indicate the date that the corrective action was completed or the proposed corrective action date if not yet corrected. If additional space is needed, please attach additional pages and include any supporting documentation.

1	General Questions	Potential Defect	Description of Defect and Corrective Action Taken/Proposed	Date Corrected/Proposed
1.1	Have there been any visible or physical indicators of unsanitary conditions?	Y N N/A		
1.2	Have there been any signs of vandalism or forced entry?	Y N N/A		
1.3	Have there been any other water quality issues within the distribution or plumbing systems (i.e. color, turbidity, taste, and odor)?	Y N N/A		

2	Operational Changes	Potential Defect	Description of Defect and Corrective Action Taken/Proposed	Date Corrected/Proposed
2.1	Has there been any other source of supply used or placed into operation that is not normally used?	Y N N/A		
2.2	Have there been any general repairs, operational changes or maintenance activities on the water system?	Y N N/A		
2.3	Was there a failure to follow adequate disinfection practices following any repairs or maintenance activities on the system?	Y N N/A		



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3	Sampling Sites	Potential Defect	Description of Defect and Corrective Action Taken/Proposed	Date Corrected/Proposed
3.1	Does the area surrounding each sampling tap appear to be unsanitary?	Y N N/A		
3.2	Are there sampling taps that are not routinely used or not identified in the system's Sampling Site Plan?	Y N N/A		
4	Sampling Protocol	Potential Defect	Description of Defect and Corrective Action Taken/Proposed	Date Corrected/Proposed
4.1	Was the sample taken in an improper sample container?	Y N N/A		
4.2	Were there any sampling or handling errors (i.e. human error)?	Y N N/A		
4.3	Were any of the sampling locations equipped with an auto sensing, swivel-or single-spout type faucet?	Y N N/A		
4.4	Did the laboratory report any testing errors?	Y N N/A		
5	Distribution	Potential Defect	Description of Defect and Corrective Action Taken/Proposed	Date Corrected/Proposed
5.1	Was an unprotected cross connection identified?	Y N N/A		
5.2	Has there been any distribution plumbing, water service or main breaks or installations?	Y N N/A		
5.3	Were there low disinfection residuals?	Y N N/A		
5.4	Have there been any incidents of low or inadequate pressure (<25 psi)?	Y N N/A		



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Ground Water Source		PWS does not have ground water sources		
6	Source Name: Source Facility ID:	Potential Defect	Description of Defect and Corrective Action Taken/Proposed	Date Corrected/Proposed
6.1	Are there any holes or unprotected openings in the well casing?	Y N N/A		
6.2	Is there any failure or outbreak of a septic or sewer system in the area around the well?	Y N N/A		
6.3	Is the well located in a depressed area where water may collect or is subject to flooding, and has any flooding or ponding occurred?	Y N N/A		
6.4	Is the sanitary seal or well cap improperly installed to the casing and electric conduit, or are they in an unsatisfactory condition?	Y N N/A		
6.5	Does the well lack a vent?	Y N N/A		
6.6	Is the vent not shielded or properly screened?	Y N N/A		
6.7	Is the well pit currently flooded or is there any indication that water collects in the pit?	Y N N/A		
6.8	Is the well pit drain line directly connected to a septic, sewer or storm drain system?	Y N N/A		

Attach additional page for each ground water source: Page ____ of ____



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PWS ID#:		PWS Name:		Town:	
Treatment Facility			PWS does not have any treatment facilities		
7	Facility Name:	Potential Defect	Description of Defect and Corrective Action Taken/Proposed	Date Corrected/Proposed	
	Treatment Facility ID:				
7.1	Has there been any by-pass in the disinfection treatment process?	Y N N/A			
7.2	Is the filter backwash discharge line directly connected to a drainage pipe or sewer/septic line?	Y N N/A			
7.3	Have there been any interruptions in disinfection treatment (UV, chlorine, etc.)?	Y N N/A			
7.4	Has there been any recent installation or repair to the treatment process?	Y N N/A			
7.5	Have there been any low or inadequate disinfection residual levels?	Y N N/A			
7.6	Is there any evidence of filter or media contamination?	Y N N/A			

Attach additional page for each treatment facility: Page ____ of ____



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8	Storage Facility	PWS does not have storage facilities		
	Facility Name:	Potential Defect	Description of Defect and Corrective Action Taken/Proposed	Date Corrected/Proposed
	Storage Facility ID:			
	Storage Type:			
8.1	Are there any holes or unprotected openings in the atmospheric tank(s)?	Y N N/A		
8.2	Is the hatch on the atmospheric tank not sealed properly?	Y N N/A		
8.3	Are the vents on the atmospheric tank <u>not</u> suitably protected and/or screened?	Y N N/A		
8.4	Is the overflow on the atmospheric tank <u>not</u> suitably protected and/or screened?	Y N N/A		
8.5	Has there been any recent work on the tank?	Y N N/A		
8.6	Is there recent evidence of unauthorized access to the tank or associated facilities?	Y N N/A		
8.7	Is there any evidence of contamination from animals?	Y N N/A		
8.8	Is there any evidence of tank failure?	Y N N/A		
8.9	Is there evidence of lack of maintenance, cleaning or inspection?	Y N N/A		

Attach additional page for each storage facility: Page ____ of ____



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PWS ID#:		PWS Name:			Town:	
Contact Information for the Person that Performed the Assessment						
Salutation		First Name		Last Name		
Organization				Job Title		
Mailing Address Line One				Mailing Address Line Two		
City			State		ZIP Code	
Business Phone (Ext.) ()		Fax	Mobile Phone	Emergency Phone		E-mail Address
Certification						
I certify that the information contained herein which is being submitted to the Connecticut Department of Public Health for a drinking water regulatory compliance purpose is complete and accurate and understand that any false statement contained herein is punishable as a criminal offense under section 53a-157b of the Connecticut General Statutes.						
Signature of Water System Owner/Legal Contact: _____				Date: _____		
Printed Name of Water System Owner/Legal Contact: _____						

Form to be completed based on an examination of the distribution system, water sources, treatment facilities, storage facilities and relevant operational practices data and documents available to the PWS and returned to the department as soon as practical but no later than 30 days after the system has identified that it had exceeded a level 1 treatment technique trigger.

Please return this form to the Drinking Water Section at:

Mail: State of Connecticut
Department of Public Health
Drinking Water Section
410 Capitol Avenue, MS# 51WAT
P.O. Box 340308
Hartford, CT 06134-0308

Email: dwdcompliance@ct.gov

Fax: 860-509-7359

DWS USE ONLY					
DWS Reviewer:					
RTCR Level 1 Assessment Accepted: YES		NO		PWS has corrected the defect (s): YES	
				NO	
DWS/PWS Consultation Date if needed:					
Corrective Action Plan Approved: YES		NO		N/A	
				Compliance Schedules Added: YES	
				NO	
Comments:					