

STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

of Public Health Revised Total Coliform Rule Level 2 Assessment Form									
PWS ID#	#: CT	PWS Name:	Town:						
Sect	ion Two – Sa	anitary Defects Identified and Co	rrective Actio	ns Schedule	Summary				
For each sanitary defect identified, provide a description of the defect along with the actions taken/proposed to correct the defect. Indicate the date that the corrective action was completed/proposed (if not yet corrected). EVERY Sanitary Defect Identified MUST have a corrective action completion date or expected corrective action completion date. Corrective actions include physical repairs/upgrades to water system components, system disinfection, training/creation of SOPs, etc.									
Defect #	PWS Facility Type (Use N/A if not applicable)	Description of Defect and Corrective A	Action Planned	Date Corrective Action was Completed	Proposed Corrective Action Due Date				
5.									
6.									
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Attach additional page for additional defects: Page



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12.						

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