STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Revised Total Coliform Rule Level 2 Assessment Form

PWS ID#: CT	PWS Name:	Town:

Section Two – Sanitary Defects Identified and Corrective Actions 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 Action Planned	Date Corrective Action was Completed	Proposed Corrective Action Due Date
5.				
6.				
7.				
8.				

Attach additional page for additional defects: Page of

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9.				
10.				
11.				
12.				

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