

## Revised Total Coliform Rule Level 2 Assessment Form

PWS ID#: CT		PWS Name:		Street:	
Assessment Trigger Date:			Town:		
Date Assessment Performed:			System Type: CWS    NTNC    TNC		
Date Assessment Form Completed*:			Water System Facility Classification*: WT    I    II    III    IV		
			*N/A for TNC                      DS    I    II    III    SW		
*Completed Form Due 30 days after Assessment Trigger Date			<a href="#">Water Quality Monitoring Schedule Link</a>		
Assessment Trigger:			<i>E. coli</i> MCL Second Level 1 Assessment in a rolling 12-month period Voluntary Level 2		
All applicable sections of this form must be completed. Please refer to <a href="#">instructions</a> for additional information.					
<h3>Section One – Field Inspection Checklist</h3> <p>Please use the checklists below to review and evaluate all the checklist elements for possible sanitary defects. Indicate Yes, No or N/A as appropriate. Provide additional detail for any questions answered "Yes" including a description of the defect and what may have caused this defect. <b>A summary of Sanitary Defects with Corrective Action Date(s) Must Be Reported in Section Two.</b> If additional space is needed, please attach additional pages and include any supporting documentation.</p>					
1	General Questions	Potential Defect	Description of Defect and Cause		
1.1	Are there any unresolved significant deficiencies from the last CT DPH Sanitary Survey?	Y N N/A			
1.2	Are there any unresolved sanitary defects identified in prior Level 1 or 2 Assessments?	Y N N/A			
1.3	Have there been any visible or physical indicators of unsanitary conditions?	Y N N/A			
1.4	Have there been any signs of vandalism or forced entry to water system components or facilities?	Y N N/A			
1.5	Have there been any other water quality issues within distribution or plumbing systems (color, turbidity, taste, and odor)?	Y N N/A			
1.6	Have there been any fire-fighting events, flushing activities, water main breaks or service line breaks which may have contributed to the bacteriological contamination?	Y N N/A			

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### Additional Information:

Have there been any community illnesses suspected of being waterborne? (e.g., Do community public health officials indicate that an outbreak has occurred?)    Y    N    N/A

Explain:

### Notes:

2	Operational Changes	Potential Defect	Description of Defect and Cause
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	
2.4	If this is a seasonal system, were there any problems during the most recent start-up procedure?	Y N N/A	

### Notes:

## Revised Total Coliform Rule Level 2 Assessment Form

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<b>3</b>	<b>Sampling Sites</b>	<b>Potential Defect</b>	<b>Description of Defect and Cause</b>
<b>3.1</b>	Does the area surrounding each sampling tap appear to be unsanitary?	Y N N/A	
<b>3.2</b>	Are there sampling taps that are not routinely used or not identified in the system's Sampling Site Plan?	Y N N/A	
Notes:			

<b>4</b>	<b>Sampling Protocol</b>	<b>Potential Defect</b>	<b>Description of Defect and Cause</b>
<b>4.1</b>	Was the sample taken in an improper sample container?	Y N N/A	
<b>4.2</b>	Were there any sampling or handling errors (i.e. human error)?	Y N N/A	
<b>4.3</b>	Were any of the sampling locations equipped with an auto sensing, swivel-or single-spout type faucet?	Y N N/A	
<b>4.4</b>	Were there any sample holding time or storage temperature exceedances?	Y N N/A	
<b>4.5</b>	Did the laboratory report any testing errors?	Y N N/A	
<b>4.6</b>	Was there a failure to follow appropriate collection procedures when samples were collected?	Y N N/A	

**Additional Information:**

Have any special samples taken from a treatment facility, well, tank or distribution system as part of the investigation confirmed the bacteriological contamination?    Y    N    N/A	Explain:
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Notes:
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## Revised Total Coliform Rule Level 2 Assessment Form

PWS ID#: CT		PWS Name:		Town:
5	Source of Supply		Source Type:	
	Source Name:	Potential Defect	Description of Defect and Cause	
	Source Facility ID:			
5.1	Have there been any recent activities (i.e. septic or sewer releases, construction, waste discharges) in the vicinity of the source?	Y N N/A		
5.2	Are there any holes or unprotected openings in the well casing?	Y N N/A		
5.3	Does the well casing terminate less than 6 inches below established grade or well pit floor?	Y N N/A		
5.4	Does the well casing terminate less than ten feet below the surface or do the casing sections not appear to be joined watertight?	Y N N/A		
5.5	Is the cover of the dug well watertight and sealed watertight to the casing?	Y N N/A		
5.6	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		
5.7	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		
5.8	Does the well lack a vent?	Y N N/A		
5.9	Is the well vent not shielded or properly screened?	Y N N/A		
5.10	Is the well pit currently flooded or is there any indication that water collects in the pit?	Y N N/A		
5.11	Is the well pit drain line directly connected to a septic, sewer or storm drain system?	Y N N/A		
5.12	Is the source in compliance with separation distance requirements associated with a potential bacterial source?	Y N N/A		
5.13	Does the spring box have any breaches, holes or unprotected openings?	Y N N/A		
5.14	Are all spring box hatches appropriately sealed and overflow vents appropriately shielded and screened?	Y N N/A		
<b>Additional Information:</b>				
Does the source have a history of bacteriological contamination? Y   N   N/A			Explain:	
Notes:				
Attach additional page for each source of supply: Page      of				

## Revised Total Coliform Rule Level 2 Assessment Form

PWS ID#: CT		PWS Name:		Town:
6	Treatment Facility		PWS does not have any treatment facilities	
	Facility Name:	Potential Defect	Description of Defect and Cause	
	Treatment Facility ID:			
6.1	Has there been any by-pass in the disinfection treatment process?	Y N N/A		
6.2	Is the filter backwash discharge line directly connected to a drainage pipe or sewer/septic line?	Y N N/A		
6.3	Have there been any interruptions in disinfection treatment (UV, chlorine, etc.)?	Y N N/A		
6.4	Has there been any recent installation or repair to the treatment process?	Y N N/A		
6.5	Have there been any low or inadequate disinfection residual levels?	Y N N/A		
6.6	Is there any evidence of filter or media contamination?	Y N N/A		
6.7	For ultraviolet (UV) disinfection systems, is the well(s) discharge flow rate (pre-UV) above the rated manufacturer's capacity of the UV unit?	Y N N/A		
6.8	For surface water treatment plants was the required inactivation CT being achieved during the time of the recent coliform positive test results?	Y N N/A		
6.9	Is the water treated with a phosphate inhibitor without the system being chlorinated?	Y N N/A		

Notes:

## Revised Total Coliform Rule Level 2 Assessment Form

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<b>7</b>	<b>Distribution</b>	<b>Potential Defect</b>	<b>Description of Defect and Cause</b>	
7.1	Have there been any incidents of low or inadequate pressure (<25 psi)?	Y N N/A		
7.2	Have there been any distribution plumbing installations, water service line breaks or main breaks?	Y N N/A		
7.3	Were there any events that may have caused flows in excess of normal?	Y N N/A		
7.4	Have all cross-connection violations been corrected?	Y N N/A		
7.5	Are there any dead end or low flow sections within the distribution system or plumbing system?	Y N N/A		
7.6	Are there any automatically operating air vacuum, air release or combination air release/air vacuum valves having a discharge port connected to drain, not screened or that may have been submerged in water?	Y N N/A		
7.7	Were there low disinfection residuals?	Y N N/A		

Notes:

**Revised Total Coliform Rule Level 2 Assessment Form**

PWS ID#: CT		PWS Name:		Town:
8	<b>Storage Facility</b>		<b>PWS does not have storage facilities</b>	
	Facility Name:	<b>Potential Defect</b>	<b>Description of Defect and Cause</b>	
	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 <u>not</u> 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	Is the overflow <u>not</u> equipped with an air gap?	Y N N/A		
8.6	Was the last atmospheric tank inspection performed more than 10 years ago? Were all deficiencies identified during the inspection corrected?	Y N N/A		
8.7	Is there any evidence of tank failure?	Y N N/A		
8.8	Has there been any work or maintenance conducted on the tank (i.e. cleaning, inspection, repairs, painting, etc.) after which it was not disinfected?	Y N N/A		
8.9	Does the in-ground storage tank <u>not meet</u> minimum separation distance requirements to drains, septic or sewer components?	Y N N/A		
	Hydropneumatic Storage Tank	N/A		
	Storage Facility ID:			
8.10	Does the air compressor for the hydro-pneumatic storage tank lack an air filter or is the air filter in poor condition?	Y N		
8.11	Is there any evidence of tank failure or has any work or maintenance been conducted on the tank after which it was not disinfected?	Y N		

Attach additional page for each storage facility: Page      of

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### Section Two – Sanitary Defects Identified and Corrective Actions Schedule Summary

1. Were all active water system facilities included as part of this Level 2 Assessment?

No - If no, explain:

Yes

2. Were any sanitary defects identified during the assessment?

No - If no, please proceed to RCTR Level 2 Assessor Information/Contact Info/Attestation section below.

Yes - If yes, please complete the Sanitary Defect and Corrective Action Summary Table below.

*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
1.				
2.				
3.				
4.				

Attach additional page for additional defects: Page      of



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PWS ID#: CT		PWS Name:		Town:	
<b>RCTR Level 2 Assessor Information</b>					
Salutation	First Name		Last Name		
Business Phone (Ext.)		E-mail Address			
CT DPH Water Operator Cert # or DCP PEN Lic#		WTP or Distribution System Operator Certification #			
<b>L2 Assessor:</b> I have attended the 6-hour Class provided by CT DPH to become a Level 2 Assessor and hold an operator certification at the same or higher classification level than that of the PWS being assessed. The RCTR Level 2 Assessor is not an employee of the public water system identified on this form.					
<b>Contact Information for the Public Water System</b>					
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	
<b>Attestation</b>					
I attest 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/Admin/Legal Contact/Certified Operator/Level 2 Assessor: _____					
Printed Name of Water System Owner/Admin/Legal Contact/Certified Operator/Level 2 Assessor: _____					
Date: _____					

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 exceeded a level 2 treatment technique trigger.

**Please return this form to the Drinking Water Section at:**

**Email:** [dwdcompliance@ct.gov](mailto:dwdcompliance@ct.gov)

**Fax:** 860-509-7359

**Mail:** State of Connecticut  
Department of Public Health  
Drinking Water Section  
410 Capitol Avenue, MS# 12-DWS  
P.O. Box 340308  
Hartford, CT 06134-0308

**Typed forms submitted electronically to [dwdcompliance@ct.gov](mailto:dwdcompliance@ct.gov) is the preferred submission method.**