



# Rockford Water Division Environmental Laboratory

Coliform Analysis Report

1111 Cedar Street  
Rockford, Illinois 61102  
815-987-5713

A. Facility No. \_\_\_\_\_ B. Facility Name: \_\_\_\_\_

C. Sampling Period: \_\_\_\_\_

D. Surface Supply: Yes  No  Date/Time Rec'd: \_\_\_\_\_

E. Chlorine Exempt: Yes  No  Date/Time Set Up: \_\_\_\_\_

Samples must reach laboratory within 30 hours after collection  
Items A-E & 1-6 must be completed or sample may be discarded.

Date/Time Read: \_\_\_\_\_

1. Mail Water Supply Copy To:  Address:  City:  2. Contact for Unsatisfactory Results: Name: _____ Phone: _____	3. Date Collected: _____ 4. Sample Collector: _____ 5. Sample Purpose: Routine <input type="checkbox"/> Replacement <input type="checkbox"/> Invalid Replacement <input type="checkbox"/> Repeat <input type="checkbox"/> Follow-Up <input type="checkbox"/> New Constuction <input type="checkbox"/> Original Lab Sample No. _____ Boil Order: <input type="checkbox"/> Other: _____ <input type="checkbox"/> Repair <input type="checkbox"/> Maintenance <input type="checkbox"/> New Constuction Permit No. _____
--	---

6. Coliform Sampling:					7.	8.	9.	10.	11.
Btl#	Sample Site# or Address -Repeat Samples - Include Site # and Address	Sample Type	Time Collected	Res. Cl.	Col Read	Total Coli	Fecal/Ecoli	Opin	Laboratory Sample No.

Method: Membrane Filter  Readycult

Analyst: \_\_\_\_\_

Lab Cert. **17597** Name: \_\_\_\_\_ COR LAB

Person Notified: \_\_\_\_\_ Date: \_\_\_\_\_  
 No. of Bottles Sent: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Replacement:  
 Samples more than 30 hours old  
 No Date/Time of Collection  
 Other: \_\_\_\_\_

