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 ☐

Replacement ☐ Invalid Replacement ☐

Repeat ☐ New Constuction ☐

Original Lab Sample No. _____

Boil Order: ☐ Other: _____ ☐

Repair ☐ Maintenance ☐

New Contruction Permit No. _____

6. Coliform Sampling:

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

Method: Membrane Filter ☐ Colilert ☐

Person Notified: _____ Date: _____

No. of Bottles Sent: _____ Date: _____

Analyst: _____

Reason for Replacement:

☐ Samples more than 30 hours old

☐ No Date/Time of Collection

☐ Other: _____

Lab Cert. **17597**

Name: _____ COR LAB

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