



Bacteriological Report

I. PWS INFORMATION: Refer to your DEP Coliform Sampling Plan to help complete the PWS Information and DEP Approved Sample Site Information sections below.

PWS ID #: PWS Name: City/Town: Class: COM NTNC TNC

II. ANALYTICAL INFORMATION: Refer to your MassDEP state lab certificate for proper Lab MA Cert.# and certified methods.

Primary Lab MA Cert.#: Primary Lab Name: Subcontracted?(Y/N):

Analysis Lab MA Cert.#: Analysis Lab:

Original Report Resubmitted Report Confirmation Report (1)Reason for Resubmission: Resample Reanalysis Report Correction

(2)Collection Date of Original Sample:

TC Method	E. Coli Method	Enterococci Method	Fecal Coliform	HPC Method	Lab Sample Notes:
1 9223 B (Collert-18)-2004 (18)	1 9223 B (Collert-18)-2004 (18)				

DEP APPROVED SAMPLE SITE INFORMATION			TOTAL COLIFORM RESULT ^{4,5}	E.COLI or FECAL RESULT ^{4,5}	CHLORINE RESULT ² mg/L	HPC RESULT ² # cfu/mL	COLLECTION		ANALYSIS		COLLECTED BY	LAB SAMPLE ID #
Sample Type ³	Location Code # ¹	DEP Approved SAMPLE LOCATION					DATE	TIME	DATE	TIME		
RS	003	Town Garage	Absent	Absent	0.65		02/14/2023	10:38	02/14/2023	16:33	client	L3B0243-01
RS	004	Mobil Station	Absent	Absent	0.66		02/14/2023	10:05	02/14/2023	16:33	client	L3B0243-02
RS	007	Timberlyn Heights Nursing Home	Absent	Absent	0.80		02/14/2023	08:43	02/14/2023	16:33	client	L3B0243-03
RS	008	Waste Water Treatment Plant	Absent	Absent	0.68		02/14/2023	09:27	02/14/2023	16:33	client	L3B0243-04
RW	RW1	Green River Pump Station	Absent	Absent			02/14/2023	08:26	02/14/2023	16:33	client	L3B0243-05
RS	EP1	Green River Pump House	Absent	Absent	0.66		02/14/2023	08:12	02/14/2023	16:33	client	L3B0243-06
RS	STOR1	Berkshire Heights Tank	Absent	Absent	0.64		02/14/2023	08:50	02/14/2023	16:33	client	L3B0243-07
RS	STOR2	Blue Hill Storage Tank	Absent	Absent	0.43		02/14/2023	09:50	02/14/2023	16:33	client	L3B0243-08

¹ DEP Sample Type, Location Code#, and DEP Approved Sample Site Location must correspond to the sample information on your DEP Total Coliform Sampling Plan


² SWTR systems: HPC samples shall be taken at the same distribution sites and at the same time as total coliform, whenever chlorine residual is not detected at the sample site.

³ Sample Type: RS-Routine Distribution Sample,RO-Original Site Repeat,UR-Upstream Repeat,DR-Downstream Repeat,AR-Additional Repeat, RW-Raw Water,PT-Plant Tap,SS-Special Sample

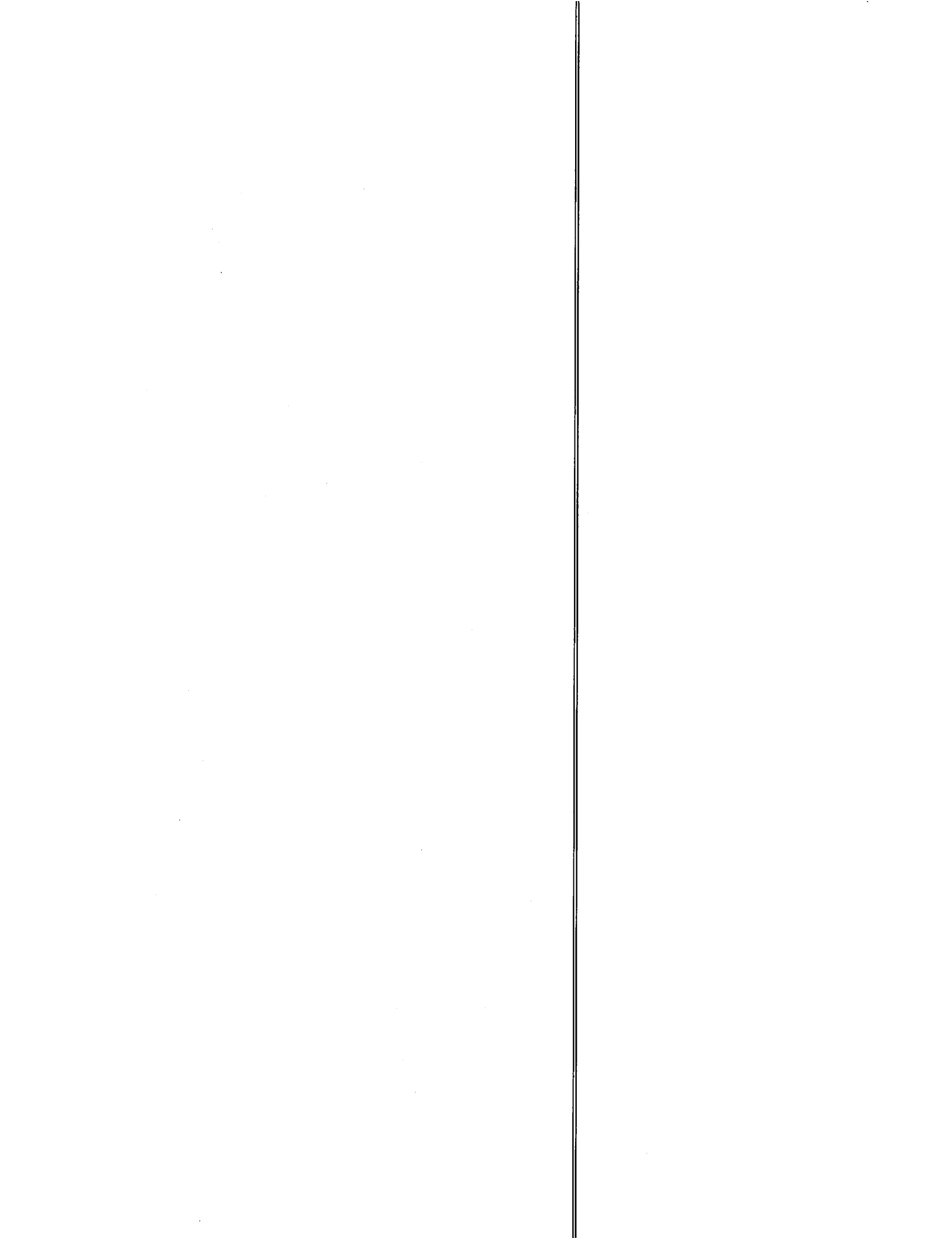
⁴ Report as #/100mL, P (present), A (absent), or Too Numerous To Count: TNTC-I (invalid) or TNCT-P (present).

⁵ Collect appropriate number of repeat samples within 24 hours of laboratory notification for coliform-positive or invalid samples. Notify DEP of any routine or repeat E.Coli or fecal positive results by the end of the business day.

I certify under penalties of law that I am the person authorized to fill out this form and the information contained herein is true, accurate and complete to the best extent of my knowledge.

Laboratory Authorized Signature and Date:  02/15/2023

DEP Review Status: Accepted Disapproved Review Comments:





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 Analysis Lab MA Cert.#: Analysis Lab:


Original Report Resubmitted Report Confirmation Report (1) Reason for Resubmission: Resample Reanalysis Report Correction (2) Collection Date of Original Sample:

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Sample Type ³	Location Code # ¹	DEP Approved SAMPLE LOCATION					DATE	TIME	DATE	TIME		
RS	005	Fairview Hospital	Absent	Absent	0.67		02/15/2023	08:20	02/15/2023	16:42	client	L3B0256-01
RS	006	Fairview Commons	Absent	Absent	0.44		02/15/2023	09:12	02/15/2023	16:42	client	L3B0256-02

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I certify under penalties of law that I am the person authorized to fill out this form and the information contained herein is true, accurate and complete to the best extent of my knowledge.

Laboratory Authorized Signature and Date:  02/16/2023

DEP Review Status: Accepted Disapproved Review Comments:

