Submit report to:

MARYLAND DEPARTMENT OF THE ENVIRONMENT

WATER SUPPLY PROGRAM

1800 Washington Blvd, Suite 450/Baltimore, MD 21230-1708
(410) 537-3729 or (800) 633-6101 ext. 3729 http://www.mde.state.md.us

FOR OFFICE USE ONLY

____ **ACCEPTED**
____ **PRELIMINARY**
____ **REJECTED**
____ **VALIDATED**

BACTERIOLOGICAL MONITORING REPORT FORM

This report must be received by the 10th day of each succeeding month in which samples were collected.
Results of invalidated samples are not to be included on this report form.

System Name ____________________

PWSID ☐☐☐ - ☐☐☐☐ **Analysis Method(s)** ____________________

Laboratory Name ____________________ **Lab ID#** ____________________

Sampler(s) (Full Name) ____________________ **Sampler ID Number(s)** ☐☐☐☐ – ☐☐

Month of Collection:
(*Check 1 Month Only*)

Jan ☐	**Feb** ☐	**Mar** ☐
Apr ☐	**May** ☐	**Jun** ☐
Jul ☐	**Aug** ☐	**Sep** ☐
Oct ☐	**Nov** ☐	**Dec** ☐

Year ______

1) **Population** __________ **Duration** ☐ **MONTHLY** ☐ **QUARTERLY** **Required number of routine samples** __________

	Routine Samples	**Repeat Samples**
2) **Number Collected & Analyzed**	**2A -**	**2B -**
Number of Total Coliform Positive	**2C -**	**2D -**
Number of Fecal/*E. coli* Positive		

3) **Percentage of Samples Total Coliform Positive:** *from Item 2 above* $\frac{(2C + 2D)}{(2A + 2B)} \times 100$ __________

4) **Complete Page 2 of this form, listing all test results reported above, if 2C is greater than "0."**

5) **Were any routine fecal coliform positives followed by (same-month) repeat coliform-positives? If YES, this is a violation – Contact MDE.** Yes ☐ No ☐

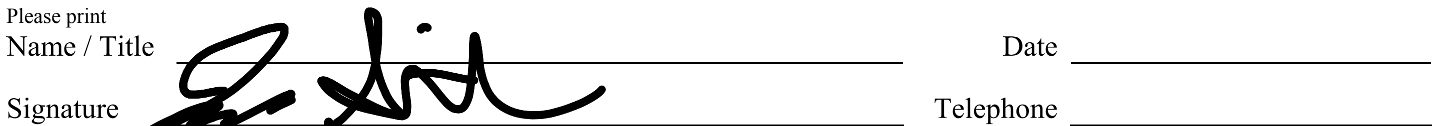
6) **Systems with ground water sources Total Number of Source Water Samples Collected:** *System must also complete and submit the Ground Water Rule Report Form, if applicable.* __________

7) **Mean Field Chlorine Residual level for Month of Collection:** *milligrams per liter (mg/L)* Systems over 3,300 persons must complete and submit the Disinfection Residual Monitoring Form quarterly. If the chlorine residual exceeded 4.0 mg/L, this may be a violation. __________

8) **Original microbiological laboratory report sheets on file and available for inspection?** Yes ☐ No ☐

I do hereby affirm that this record contains no willful misrepresentations or falsifications and that this information given by me is true and complete to the best of my knowledge and belief.

Please print
Name / Title ____________________ Date ____________________



Signature ____________________ Telephone ____________________

 PWSID_________

Note: Page 2 should be completed when there are positive bacteriological samples for the monitoring period.

Bacteriological Results of Samples

Sample Date	Sample Point Location	Sample Type	Repeat Location	TC	FC	EC	Count	Interference /Rejection	Remarks

Sample Type: RT = Routine; RP= Repeat; TG = Triggered Ground Water Rule

Repeat Location: UP – upstream within 5 connections of the original sample location
DN – downstream within 5 connections of the original sample location
OR – original site
OT – other

TC/FC/EC: The Absence and Presence indicators or used to indicate the existence of coliform in the sample.
A- Absent; negative (-)
P – Present; positive (+)

Count: (optional) This field is only available if total coliform is found to be present. Count will accept 5 decimal places.

Interference/Rejection: For a TCR result that may be invalidated. STATE –reason as determined by the State.
Laboratory codes: TNTC – Too numerous to count CNFG – Confluent Growth TCNG – Turbid culture, no gas