STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Revised Total Coliform Rule Level 1 Assessment Form

PWS ID#: CT	PWS Name:	Town:

7	Treatment Facility Facility Name: Treatment Facility ID:	Potential Defect	☐ PWS does not have any treatment facilities Description of Defect and Corrective Action Taken/Proposed	Date Corrected/ Proposed
7.1	Has there been any by-pass in the disinfection treatment process?	○ Y ○ N ○ N/A		
7.2	Is the filter backwash discharge line directly connected to a drainage pipe or sewer/septic line?	○ Y ○ N ○ N/A		
7.3	Have there been any interruptions in disinfection treatment (UV, chlorine, etc.)?	○ Y ○ N ○ N/A		
7.4	Has there been any recent installation or repair to the treatment process?	○ Y ○ N ○ N/A		
7.5	Have there been any low or inadequate disinfection residual levels?	○ Y ○ N ○ N/A		
7.6	Is there any evidence of filter or media contamination?	○ Y ○ N ○ N/A		

Attach additional page for each treatment facility: Page ____ of ____