



Lab Certification (ELAP) #1664

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LAB ORDER #:

## COLIFORM BACTERIA ANALYSIS

### CLIENT INFORMATION:

Client \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ Phone \_\_\_\_\_  
 City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
 Project Name \_\_\_\_\_  
 Sampler Name \_\_\_\_\_

### Reporting Options:

Mail Hardcopy (default) - Please fill-in complete address on reverse side of page  
 Email (please print): \_\_\_\_\_  
 Email cc (please print): \_\_\_\_\_  
 Regulator Email (if applicable): \_\_\_\_\_

Check here for **RUSH** Turnaround\*

\*Sample must be received by 3 PM and paid in full in order to receive results by end of the next business day.

Check here if this sample is used for regulatory purposes.  
 Check below to have lab send copy to a regulatory office  
 NCEH  CDPH.SR  CDPH.RICH  
 Other (county/agency): \_\_\_\_\_  
 Sample Type (circle one - required)  
 Routine Repeat Raw Special  
 CDPH System #: \_\_\_\_\_ (required)

Fill the container to BETWEEN the 100mL and 120mL LINES AND RETURN TO LAB WITHIN 12 HOURS.

SAMPLE #	SAMPLE DATE	SAMPLE TIME	SAMPLE LOCATION DESCRIPTION	Field Chlorine Residual	Total Coliform		E. Coli	
					Present	Absent	Present	Absent
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### LAB USE ONLY

Notification Req? Y N Initials: \_\_\_\_\_ Date/Time: \_\_\_\_\_  
 Contact: \_\_\_\_\_ Date/Time Set: \_\_\_\_\_ / \_\_\_\_\_  
 \_\_\_\_\_ Date/Time Read Out: \_\_\_\_\_ / \_\_\_\_\_  
 Entered By: \_\_\_\_\_ Reviewed By: \_\_\_\_\_ Analyst(s): \_\_\_\_\_

**ONLY THE STATEMENT 'TOTAL COLIFORM ABSENT' MEANS THAT THE WATER MEETS THE BACTERIAL REQUIREMENTS OF THE STATE HEALTH AND SAFETY CODES FOR POTABLE WATER.**

Submitted By: (Print & Sign)	Date	Received By:	Temp: _____ / _____ °C
	Time		Sealed: Y / N
Submitted By: (Print & Sign)	Date	Received By:	Intact: Y / N
	Time		On ice: Y / N