



Lab Certification (ELAP) #1664

1885 North Kelly Road
 Napa, CA 94558
 Phone: (707) 258-4000
 info@caltestlabs.com
 www.caltestlabs.com

LAB ORDER #:

Check here for **RUSH** Turnaround*

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

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 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: _____

Sample Type (circle one - required)
 Routine Repeat Raw Special

CDPH System #: _____
 (required)

Fill the container to **BETWEEN** the 100mL & 120mL lines. Return to the lab, **on ice, 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 Read Out: _____
 _____ PM: _____ Entered: _____ Reviewed: _____ 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

Comments: _____

If sample results indicate the presence of coliform bacteria, the following decontamination procedures have been recommended by County Environmental Health Departments:

1. If water is cloudy, pump the well until the water appears to be clear.
2. Mix one gallon household bleach containing 5.25% sodium hypochlorite to three gallons of water. Greater amounts or stronger chlorine solutions should be used for wells of more than 100 feet deep.
3. The chlorine solution is then poured into the well. It may be necessary to lift the pump, but some wells have openings which can be used for this purpose.
4. Do not operate the pump for 30 minutes. After the 30 minute period, with the taps, faucets and hydrants open or closed, surge the well by starting and stopping the pump several times.
5. Open every tap, faucet or hydrant in the water piping system, start the pump and let the water flow until clean water with a strong odor of chlorine comes out.
6. Stop the pump and close all the taps, faucets and hydrants. Do not operate the pump for 24 hours.
7. After 24 hours, open all outside taps, faucets and hydrants and let the water flow until the odor of chlorine is gone. Do not discharge heavily chlorinated water into an individual sewage disposal system.
8. A water sample for bacteriological analysis should be obtained one week or more after disinfecting the well.

NOTE: Make sure that your well is tightly sealed to keep out rodents, insects, dirt and surface water seepage.
For storage tanks, use of 4 ounces of household bleach per 1000 gallons should provide 5ppm of free residual chlorine.

For additional information contact your County Health Department.

Rev 12.01.2023



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