



Drinking Water Protection Section
 P.O. Box 64975-0975
 St. Paul, MN 55164-0975
 651/201-4700; FAX: 651/201-4701

Bacteriological/Disinfectant Residual Monthly Report

Public Water System ID			Laboratory Certification ID			
Name of Water System			Laboratory Name		Analyst Name	
System Address			Total Coliform Analysis Method		E.Coli Method	
			<input type="checkbox"/> Membrane Filter <input type="checkbox"/> MPN 10 ml <input type="checkbox"/> Colilert <input type="checkbox"/> MPN 100 ml		<input type="checkbox"/> Colilert <input type="checkbox"/> Colisure <input type="checkbox"/> Membrane	
System City		Zip	Phone (including area code)		<input type="checkbox"/> I verify that this report is accurate.	
Phone						

Routine Samples

Report For MM/YY	Number of Samples Required Per Month	Number of Samples Collected	Number of Sites Where D.R. Was Measured	Monthly Average D.R. (Total Chlorine or Chloramine, mg/l)	Number of Samples Positive For Total Coliform	Number of Samples Positive For E.Coli	Percent of Samples Positive for Total Coliform (for systems required to collect 40 or more samples)

Original Positive Samples

Collection Date	Source/Well #(s) or Distribution Location (address or name of facility)	Analysis Date	Results (Total coliform/E.Coli)

Repeat Samples (Lab may attach sheet with additional repeat sample locations.)

Collection Date	Source/Well #(s) or Distribution Location (address or name of facility)	Analysis Date	Results (Total coliform/E.Coli)

Instructions for Completing Bacteriological/Disinfectant Residual Monthly Report

This form summarizes all total coliform test results for a given month, at a given Public Water System (PWS), and must be submitted to the Minnesota Department of Health (MDH) **by the 10th of each month** (i.e., June results are required to be reported by July 10th; July results by August 10th, etc.).

Copies of the completed form must be provided to (a) the PWS, (b) the MDH Drinking Water Protection Section, and (c) a copy maintained at your laboratory.

Your laboratory must call the MDH and the PWS to report any positive result(s). A hard copy of the total coliform positive result(s) must be provided to the MDH contact person and the PWS **within 24 hours**. Positive E. coli result(s) must be reported **immediately**.

PWSID – Identification number assigned by the MDH Drinking Water Protection Section. This 7-digit number **must** be filled in, and if you do not know the PWSID, contact the PWS.

LAB ID – Identification number assigned by the MDH Laboratory Certification Program.

D.R. – Disinfectant Residual (total chlorine or chloramine) results for systems that disinfect. The PWS will provide your laboratory with D.R. field analysis results. Field analysis results must be collected at the same location and time as the total coliform samples and recorded on the laboratory form.

Repeat Samples

Collection Date – All repeat samples should be collected during a single day, and within 24 hours of notification of the original distribution system coliform positive result (original positive).

Source/Well #(s) OR Distribution Locations – Sample locations to follow up with **each** original positive – Original, Upstream, Downstream, Another – and at **each** groundwater source that was being pumped when the original positive sample was collected and during the week prior.

Analyses Dates – The analysis date for each repeat sample.

If you have any questions, please contact:
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David Rindal at 651-201-4660, david.rindal@state.mn.us