



Louisiana Department of Health and Hospitals, Office of Public Health
Engineering Services – Safe Drinking Water Program
RTCR Level 1 Assessment Form

PWS ID#:LA	PWS Name:	Parish:
-------------------	------------------	----------------

LDHH Notification Date (mm/dd/yy)	Assessment Date: (mm/dd/yy)
--	------------------------------------

INSTRUCTIONS: Complete all Sections, Certify with Signature(s) and Submit to LDHH by ()

In **Section A**, review and evaluate the listed elements typically found at a PWS. For the two week period preceding the positive coliform sample(s), check (✓) all elements reviewed and check (✓) “Yes” if any Sanitary Defects (e.g., pathway of entry for microbial contamination) were identified, check (✓) “No” if sanitary defects were not identified, or check (✓) “NA” if the section is not applicable to the PWS.
 In **Section B “Description of Occurrence”** provide an explanation of any sanitary defects identified.
 In **Section C “Corrective Action”** provide proposed corrective action(s) of any sanitary defects identified in Section B.
Return this form within 30 days after the LDHH Notification Date of the RTCR Level 1 Trigger.

Section A

1. SOURCES Sanitary Defects: Yes No

<p>General (Surface or Ground water)</p> <input type="checkbox"/> change in source (new or inactivated source) <input type="checkbox"/> potential source of contamination <input type="checkbox"/> operation/maintenance activities <input type="checkbox"/> visible indicators of unsanitary conditions <input type="checkbox"/> signs of vandalism/forced entry* <input type="checkbox"/> water quality parameters out of range <input type="checkbox"/> extreme weather conditions (e.g., drought, heavy rains, etc.) <input type="checkbox"/> other:	<p>Wells</p> <input type="checkbox"/> flood water and/or run-off inundation <input type="checkbox"/> defective/damaged well cap/well seal/well casing <input type="checkbox"/> damaged well casing <input type="checkbox"/> damaged/unscreened vent <input type="checkbox"/> inadequate grout seal <input type="checkbox"/> inadequate depth of grout <input type="checkbox"/> unprotected opening in pump/pump assembly
--	---

* Report any malicious intent or an act of vandalism to DHH within two hours.

2. TREATMENT PROCESS Sanitary Defects: Yes No NA**

<input type="checkbox"/> change in flow rates <input type="checkbox"/> interruptions in treatment/power loss <input type="checkbox"/> treatment added or changed <input type="checkbox"/> inadequate disinfection	<input type="checkbox"/> turbidity measurements out of range <input type="checkbox"/> O & M procedures not followed <input type="checkbox"/> recent installation/repair <input type="checkbox"/> other:
--	--

3. SAMPLE SITE Sanitary Defects: Yes No

<input type="checkbox"/> a domestic or other non-distribution system plumbing problem	<input type="checkbox"/> other:
---	---------------------------------

4. DISTRIBUTION SYSTEM Sanitary Defects: Yes No

<input type="checkbox"/> pressure loss/inadequate pressure (<20 psi) <input type="checkbox"/> standing water/debris in valve/relief vault <input type="checkbox"/> low disinfection residuals <input type="checkbox"/> pump or valve failure <input type="checkbox"/> firefighting event/flushing/sheared hydrant <input type="checkbox"/> improper surge control <input type="checkbox"/> improper operation of valves <input type="checkbox"/> unprotected cross connection <input type="checkbox"/> leaks	<input type="checkbox"/> operation of isolation valves resulting in breakage <input type="checkbox"/> flushing of fire hydrants or blow-offs <input type="checkbox"/> improper operation or installation of air-relief valves/blow off <input type="checkbox"/> installation of new mains or construction activity <input type="checkbox"/> improper operation of pumps/valves <input type="checkbox"/> improper use of hydrants <input type="checkbox"/> main break(s) 30 days prior to TC+/E.coli+ sample <input type="checkbox"/> other:
---	--

5. STORAGE TANKS Sanitary Defects: Yes No NA**

<input type="checkbox"/> deterioration, rust, holes, leaks, or other breaches in tank wall, drain pipe, vent, overflow pipe, ladders, etc. <input type="checkbox"/> incorrect operation of level control valves, altitude valves, and related appurtenances <input type="checkbox"/> improper maintenance practices (no inspection within 5 years) <input type="checkbox"/> presence of dead animals/insects <input type="checkbox"/> inadequate air gap for overflow or vent termination <input type="checkbox"/> signs of vandalism/forced entry	<input type="checkbox"/> low disinfectant residual <input type="checkbox"/> screen compromised or wrong mesh size <input type="checkbox"/> access hatch not sealed <input type="checkbox"/> other:
---	---

** NA (not applicable) should be checked if the PWS does not have that component (i.e. no storage tanks)

Section B - Description of Occurrence of Sanitary Defects: Use this space to provide additional information that supports your findings (i.e. water quality and pressure monitoring data). Include corresponding dates with your findings.

Check if PWS did not find any sanitary defects.

Section C - Corrective Action Use this space to describe corrective action taken or proposed corrective action with corresponding dates.

First coliform detection date: / /		Second coliform detection date: / /	
Total# routine and repeat samples:	Total# coliform positive samples:	Total# <i>E. coli</i> positive samples:	
Total# triggered GW sample total coliform positive:		Total# triggered GW sample <i>E. coli</i> positive:	
Note: A RTCR <u>Level 2</u> Assessment is required when two (2) Level 1 Assessments occur within a 12 month period or when one of the two coliform positive samples is also paired with an <i>E. coli</i> positive (Acute MCL)			

Certified Operator (print name):		Operator ID:	
Distribution Level (1-4)	Production Level (1-4)	Treatment Level (1-4)	
Sample Collector(s) (<input type="checkbox"/> same as Certified Operator):			

Certification: I certify under penalty of law that I am the person authorized to fill out this form, and the information contained herein is true, accurate and complete to the best of my knowledge and belief.

Print
 Name: _____ Title: _____
 Signature: _____ Date: _____
 Email: _____ Phone: _____

Please return this form to the **LDHH Safe Drinking Water Program** district office where the system is located - find district office address at: www.dhh.la.gov/SafeDrinkingWater

SDWP USE ONLY: Date received: / / SDWP Reviewer: _____