

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
WATER BACTERIOLOGICAL ANALYSIS

SAMPLE COLLECTION: READ INSTRUCTIONS ON BACK OF GOLDENROD COPY
If instructions are not followed, sample will be rejected.

DATE COLLECTED MONTH 11 / 25 / 98 YEAR 98	TIME COLLECTED 9:36 AM	COUNTY NAME King
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TYPE OF SYSTEM <input checked="" type="checkbox"/> PUBLIC <input type="checkbox"/> INDIVIDUAL (Serves only 1 residence)	IF PUBLIC SYSTEM, COMPLETE: I.D. No. 40950K	CIRCLE GROUP <input checked="" type="radio"/> A <input type="radio"/> B
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NAME OF SYSTEM
KCWD 83

SPECIFIC LOCATION WHERE SAMPLE COLLECTED 18926 33 AV NE	TELEPHONE NO. DAY (206) 365-3211
	EVENING ()

SAMPLE COLLECTED BY: (Name) Alex Mock	SYSTEM OWNER/MGR.: (Name) P. Lay
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SOURCE TYPE
 SURFACE GROUND WATER UNDER SURFACE INFLUENCE
 WELL or WELL FIELD SPRING PURCHASED or INTERTIE COMBINATION or OTHER

SEND REPORT TO: (Print Full Name, Address and Zip Code)
King County Water District # 83
4029 NE 178th St.
Lake Forest Park, WA 98155

TYPE OF SAMPLE (check only one in this column)

ROUTINE DRINKING WATER check treatment →

REPEAT SAMPLE
Previous coliform presence Lab # _____
Date Collected ____/____/____

RAW SOURCE WATER Source # S Total Coliform
 NEW CONSTRUCTION or REPAIRS Fecal Coliform

OTHER (Specify) **Engineering**

REMARKS: P/A

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
WATER BACTERIOLOGICAL ANALYSIS

SAMPLE COLLECTION: READ INSTRUCTIONS ON BACK OF GOLDENROD COPY
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DATE COLLECTED MONTH 11 / 25 / 98 YEAR 98	TIME COLLECTED 9:28 AM	COUNTY NAME King
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TYPE OF SYSTEM <input checked="" type="checkbox"/> PUBLIC <input type="checkbox"/> INDIVIDUAL (Serves only 1 residence)	IF PUBLIC SYSTEM, COMPLETE: I.D. No. 40950K	CIRCLE GROUP <input checked="" type="radio"/> A <input type="radio"/> B
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NAME OF SYSTEM
KCWD 83

SPECIFIC LOCATION WHERE SAMPLE COLLECTED 3945 NE 186 ST	TELEPHONE NO. DAY (206) 365-3211
	EVENING () Same

SAMPLE COLLECTED BY: (Name) Alex Mock	SYSTEM OWNER/MGR.: (Name) P. Lay
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SOURCE TYPE
 SURFACE GROUND WATER UNDER SURFACE INFLUENCE
 WELL or WELL FIELD SPRING PURCHASED or INTERTIE COMBINATION or OTHER

SEND REPORT TO: (Print Full Name, Address and Zip Code)
King County Water District # 83
4029 NE 178th St.
Lake Forest Park, WA 98155

TYPE OF SAMPLE (check only one in this column)

ROUTINE DRINKING WATER check treatment →

REPEAT SAMPLE
Previous coliform presence Lab # _____
Date Collected ____/____/____

RAW SOURCE WATER Source # S Total Coliform
 NEW CONSTRUCTION or REPAIRS Fecal Coliform

OTHER (Specify) **Engineering**

REMARKS: P/A

(LAB USE ONLY) DRINKING WATER RESULTS

UNSATISFACTORY, Coliforms present SATISFACTORY Coliforms absent

REPEAT SAMPLES REQUIRED E. Coli present E. Coli absent
 Fecal present Fecal absent

OTHER LABORATORY RESULTS

TOTAL COLIFORM _____ / 100ml E. COLI _____ / 100ml
FECAL COLIFORM _____ / 100ml PLATE COUNT _____ / ml

ANOTHER SAMPLE REQUIRED

SAMPLE NOT TESTED BECAUSE:
 Sample too old Wrong container Incomplete form

TEST UNSUITABLE BECAUSE:
 Confluent growth TNTC Turbid culture Excess debris

(LAB USE ONLY) DRINKING WATER RESULTS

UNSATISFACTORY, Coliforms present SATISFACTORY Coliforms absent

REPEAT SAMPLES REQUIRED E. Coli present E. Coli absent
 Fecal present Fecal absent

OTHER LABORATORY RESULTS

TOTAL COLIFORM _____ / 100ml E. COLI _____ / 100ml
FECAL COLIFORM _____ / 100ml PLATE COUNT _____ / ml

ANOTHER SAMPLE REQUIRED

SAMPLE NOT TESTED BECAUSE:
 Sample too old Wrong container Incomplete form

TEST UNSUITABLE BECAUSE:
 Confluent growth TNTC Turbid culture Excess debris

SEE REVERSE SIDE OF GREEN COPY FOR EXPLANATION OF RESULTS

SEE REVERSE SIDE OF GREEN COPY FOR EXPLANATION OF RESULTS

LAB NO. (7 DIGITS) 6608399	DATE, TIME RECEIVED 11/25/98 10:55 AM	RECEIVED BY [Signature]
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DATE REPORTED 11/30/98	LABORATORY: AM TEST INC. 14603 NE 87th Street Redmond, WA 98052
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REMARKS: 6608399
DP CENTER COPY

LAB NO. (7 DIGITS) 6608400	DATE, TIME RECEIVED 11/25/98 10:55 AM	RECEIVED BY [Signature]
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DATE REPORTED 11/30/98	LABORATORY: AM TEST INC. 14603 NE 87th Street Redmond, WA 98052
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REMARKS: 6608400
DP CENTER COPY

DOH 305-002 (REV 7/92)

DOH 305-002 (REV 7/92)

**STATE OF WASHINGTON
DEPARTMENT OF HEALTH
WATER BACTERIOLOGICAL ANALYSIS**

SAMPLE COLLECTION: READ INSTRUCTIONS ON BACK OF GOLDENROD COPY
If instructions are not followed, sample will be rejected.

DATE COLLECTED MONTH <u>11</u> DAY <u>26</u> YEAR <u>98</u>	TIME COLLECTED <u>9:53</u> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>	COUNTY NAME <u>King</u>
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TYPE OF SYSTEM <input checked="" type="checkbox"/> PUBLIC <input type="checkbox"/> INDIVIDUAL (Serves only 1 residence)	IF PUBLIC SYSTEM, COMPLETE: I.D. No. <u>40950K</u>	CIRCLE GROUP <input checked="" type="radio"/> A <input type="radio"/> B
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NAME OF SYSTEM
KCWD 83

SPECIFIC LOCATION WHERE SAMPLE COLLECTED <u>4029 NE 178 ST</u>	TELEPHONE NO. DAY (<u>206</u>) <u>365-3211</u> EVENING ()
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SAMPLE COLLECTED BY: (Name) <u>Alex Mock</u>	SYSTEM OWNER/MGR.: (Name) <u>P. Lay</u>
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SOURCE TYPE GROUND WATER UNDER SURFACE INFLUENCE
 SURFACE WELL or WELL FIELD SPRING PURCHASED or INTERTIE COMBINATION or OTHER

SEND REPORT TO: (Full Name, Address and Zip Code)
King County Water District # 83
4029 NE 178th St.
Lake Forest Park, WA 98155

WASHINGTON

TYPE OF SAMPLE (check only one in this column)

<input type="checkbox"/> ROUTINE DRINKING WATER check treatment →	<input type="checkbox"/> Chlorinated (Residual: _____ Total _____ Free)
<input type="checkbox"/> REPEAT SAMPLE Previous coliform presence Lab # _____ Date Collected _____	<input type="checkbox"/> Filtered
<input type="checkbox"/> RAW SOURCE WATER Source # <u>S</u> <input type="checkbox"/> Total Coliform	<input type="checkbox"/> Untreated or Other _____
<input type="checkbox"/> NEW CONSTRUCTION or REPAIRS	<input type="checkbox"/> Fecal Coliform
<input checked="" type="checkbox"/> OTHER (Specify) <u>ENGINEERING</u>	

REMARKS: P/A

(LAB USE ONLY) DRINKING WATER RESULTS	
<input type="checkbox"/> UNSATISFACTORY, Coliforms present	<input checked="" type="checkbox"/> SATISFACTORY Coliforms absent
REPEAT SAMPLES REQUIRED <input type="checkbox"/> E. Coli present <input type="checkbox"/> E. Coli absent <input type="checkbox"/> Fecal present <input type="checkbox"/> Fecal absent	
OTHER LABORATORY RESULTS	
TOTAL COLIFORM _____ / 100ml	E. COLI _____ / 100ml
FECAL COLIFORM _____ / 100ml	PLATE COUNT _____ / ml
ANOTHER SAMPLE REQUIRED	
SAMPLE NOT TESTED BECAUSE: <input type="checkbox"/> Sample too old <input type="checkbox"/> Wrong container <input type="checkbox"/> Incomplete form <input type="checkbox"/> _____	TEST UNSUITABLE BECAUSE: <input type="checkbox"/> Confluent growth <input type="checkbox"/> TNTC <input type="checkbox"/> Turbid culture <input type="checkbox"/> Excess debris

SEE REVERSE SIDE OF GREEN COPY FOR EXPLANATION OF RESULTS

LAB NO. (7 DIGITS) <u>6608401</u>	DATE, TIME RECEIVED <u>11/25/98 10:55 AM</u>	RECEIVED BY <u>[Signature]</u>
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DATE REPORTED <u>11/30/98</u>	LABORATORY: <u>AM TEST INC.</u>
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14603 NE 87th Street
Redmond, WA 98052