Arkansas Department of Health

Clear Form

RTCR Level 1 Assessment Form

System Name:	**Source Water:**	**PWSID #**
System Type:	**Population Served:**	**PWS Address:**
Operator in Responsible Charge (ORC):	**Phone:**	
City, State:		
County:		**Sample Site info:**
Person that collected TC samples if different than ORC:	**Phone:**	
Address, City, State, Zip:		
Date Assessment Completed:	**Completed by:**	

Questions (1-4)	Reviewed? (Y/N or N/A)	Issue(s) Found? (Y/N)	Issue Description	Corrective Action Taken (Including Date)
1. Evaluate sample site. -condition or location of tap -regular use of tap/service -POE/POU -adequate disinfectant level maintained -history of sample results from site -softeners				
2. Sample protocol followed and reviewed. -flush tap -remove aerator -no swivel -disinfect/sterilize tap -sample storage acceptable -fresh sample bottles				
3. Have any of the following occurred at relevant facilities prior to the collection of TC samples? -any interruptions or upsets in the treatment process -any reported loss of pressure events -reported vandalism and/or unauthorized access to facilities -visible indicators of unsanitary conditions reported -Has there been a fire fighting event, flushing operation, sheared hydrant, etc.				
4. Have there been any recent operational changes to the system? -sources introduced -treatment or operational changes -maintenance activities -potential sources of contamination				

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Questions (5-8)	Reviewed? (Y/N or N/A)	Issue(s) Found? (Y/N)	Issue Description	Corrective Action Taken (Including Date)
5. Distribution System -system pressure -cross connection -pump station -repairs -air relief valves -fire hydrants or blow off -breaks				
6. Storage Tank -screens -security -access opening -condition of tank -vent -drain / overflow -pressure tank -O&M				
7. Treatment Process -interruptions / upsets -O&M -monitoring				
8. Source - Well -sanitary seal -vent screened -air gap -pump to waste line -cross connection -security **Spring** -condition of spring development -condition of spring box -security **Surface Water** -heavy rainfall -high turbidity -lake turnover -algae blooms -other impacts				

Additional Comments:

Name of person completing form: _____ **Signature:** _____ **Date:** _____

Title and Organization: _____

Complete the assessment and submit this form within 30 days to:

Engineering Section, Slot 37
Arkansas Department of Health
4815 W. Markham St.
Little Rock, AR 72205

Reserved for State

1. Assessment has been successfully completed. (Y/N & Date)	
2. Likely reason for total coliform positives occurrence is established.	
3. System has corrected the problem. (Y/N & Date)	
4. Was a reset requested and / or granted? – Rationale	
5. Name of State reviewer:	