

INSTRUCTIONS ON REVERSE SIDE



210 Addison Ave, PO Box 1867
 Twin Falls, ID 83301
 Phone: (208) 733-4250
 Fax: (208) 734-2539
 www.magicvalleylabs.com

Brenda Ellis Laboratory Supervisor

--Shaded areas must be completed or sample will not be accepted.
 --Private samples do not require PWS# or chlorine residual.
 --Non-shaded areas are for Lab use only
 --Samples will be analyzed for **TOTAL COLIFORM** unless specified otherwise under "Remarks".
 --Public Systems: ORIGINAL POSITIVE SAMPLE DATE must be recorded for repeat samples.

Public Drinking Water System
 Private Drinking Water

PAYMENT METHOD

Private samples must include \$18.00 payment

No Charge
 Bill
 Prepaid
 Payment Received with Sample Receipt #: _____

Water System Name		PWS ID No.
Collector	Date Collected	County
Person Transporting Sample to Lab		
Condition of Transport	Cooled	<input type="checkbox"/> Carrier <input type="checkbox"/>
	Mail	<input type="checkbox"/> Other <input type="checkbox"/>
REPORT RESULTS TO:		
Name		
Address		
City	State	Zip Code
Phone Number	Fax Number	

R E S U L T S

Sample Number	Sample Type Code	Sample Location	Time Collected	Chlorine Residual PPM	Original Sample Date	TOTAL COLIFORM			ESCHERICHIA COLI
						Method Code	(P)resent (A)bsent #100ML	(P)resent (A)bsent #100ML	
						SM 9223B			
						CT CT18 CS			
						SM 9223B			
						CT CT18 CS			
						SM 9223B			
						CT CT18 CS			
						SM 9223B			
						CT CT18 CS			

Sample Type Codes: S - Routine Sample U - Upstream Repeat E - Enforcement W - Untreated (source)
 P - Repeat Sample D - Downstream Repeat X - Other Repeat C - Construction/Special

Chain-of-Custody Information

Relinquished by:	Date:	Time:	Received by:	Date:	Time:	Relinquished by:	Date:	Time:
Relinquished by:	Date:	Time:	Received by:	Date:	Time:	Relinquished by:	Date:	Time:

Received Date/Time _____
 Analysis Start Date/Time _____ Initials _____ Reviewed by: _____
 Analysis Complete Date/Time _____ Initials _____

REMARKS: _____

