LOUISIANA DEPARTMENT OF HEALTH
Engineering Services

Safe Drinking Water Program
RTCR Level 1 Assessment Form

PWS ID#:LA	PWS Name:	Parish:
LDHH Notification Date (mm/dd/yyyy)	Assessment Date: (mm/dd/yy)	

INSTRUCTIONS: **Complete all Sections, Certify with Signature(s) and Submit to LDH**

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

General (Surface or Ground water)

- ☐ change in source (new or inactivated source)
- ☐ potential source of contamination
- ☐ operation/maintenance activities
- ☐ visible indicators of unsanitary conditions
- ☐ signs of vandalism/forced entry*
- ☐ water quality parameters out of range
- ☐ extreme weather conditions (*e.g.*, drought, heavy rains, etc.)
- ☐ other:

Wells

- ☐ flood water and/or run-off inundation
- ☐ defective/damaged well cap/well seal/well casing
- ☐ damaged well casing
- ☐ damaged/unscreened vent
- ☐ inadequate grout seal
- ☐ inadequate depth of grout
- ☐ 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**

- ☐ change in flow rates
- ☐ interruptions in treatment/power loss
- ☐ treatment added or changed
- ☐ inadequate disinfection
- ☐ turbidity measurements out of range
- ☐ O & M procedures not followed
- ☐ recent installation/repair
- ☐ other:

3. SAMPLE SITE — Sanitary Defects: ☐ Yes ☐ No

- ☐ a domestic or other non-distribution system plumbing problem
- ☐ other:

4. DISTRIBUTION SYSTEM — Sanitary Defects: ☐ Yes ☐ No

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

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

- ☐ deterioration, rust, holes, leaks, or other breaches in tank wall, drain pipe, vent, overflow pipe, ladders, etc.
- ☐ incorrect operation of level control valves, altitude valves, and related appurtenances
- ☐ improper maintenance practices (no inspection within 5 years)
- ☐ presence of dead animals/insects
- ☐ inadequate air gap for overflow or vent termination
- ☐ signs of vandalism/forced entry
- ☐ low disinfectant residual
- ☐ screen compromised or wrong mesh size
- ☐ access hatch not sealed
- ☐ 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# *E. coli* positive samples:
Total# triggered GW sample total coliform positive:	Total# triggered GW sample *E. coli* positive:	
Note: A RTCR **Level 2** 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 *E. coli* positive (Acute MCL)		

Certified Operator (print name):	Operator ID:	
Distribution Level (1-4)	Production Level (1-4)	Treatment Level (1-4)
Sample Collector(s) (☐ 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 **LDH Safe Drinking Water Program** district office where the system is located - find district office address at: www.ldh.la.gov/SafeDrinkingWater

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