|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **RTCR Level 1 Assessment Form** | | | | | | | | |  | | | |  | | |
| **PWSID Name:** | | | | | **PWS #** | | | | |  | | | |  | |
| **Date Assessment Completed** | |  | | | | | | | |  | | | |  | | |
| **INSTRUCTIONS** | | | | | | | | | |  | | | |  | | |
| In **Section A** review and evaluate the listed elements typically found in a PWS. Check (√) all elements reviewed and describe any issues identified and if any potential causes of contamination were identified. If potential causes were identified, describe the corrective actions taken and the date of work completed. Check (√) “No issues” if potential causes of contamination were not identified, or check (√) “NA” if the section is not applicable to the PWS.  **Return this form within 30 days from Notification letter date**. | | | | | | | | | |  | | | |  | | |
| **SECTION A** | | | | | | | | | |  | | | |  | | |
| **1. GENERAL** | | | | | | | | | | **Issue Description** | | | | **Corrective Action taken and date** | | |
| **Sanitary Survey Info: Date of last Sanitary Survey \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_** | | | | | | | | | |  | | | |  | | |
| Any significant deficiencies, sanitary defects, or recommendations made in last Sanitary Survey?  No issues  Issue(s) identified\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have these been corrected?  No  Yes – Brief explanation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |  | | | |  | | |
| **Have any of the following occurred at sample sites prior to collection bacteria samples?** | | | | | | | | | |  | | | |  | | |
| low/inadequate disinfectant residual | | | | loss of pressure (<20 psi) | | | | | |  | | | |  | | |
| operation/maintenance activities | | | | visible indicators of unsanitary conditions | | | | | |  | | | |  | | |
| firefighting event/flushing/sheared hydrant | | | | water quality parameters out of range | | | | | |  | | | |  | | |
| signs of vandalism/forced entry | | | | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  | | | |  | | |
| **2. OPERATIONAL CHANGES** | | | | **No issues** | | | | **N/A** | |  | | | | | |
| potential source of contamination | | | | new source | | | | | |  | | | |  | | |
| change in operator | | | | other: | | | | | |  | | | |  | | |
| **3. SAMPLING SITES** | | | | **No issues** | | | | **N/A** | | | |  | | | |
| unclean or unsuitable sample tap | | | | change in conditions at sample site | | | | | |  | | | |  | | |
| hot water intrusion | | | | other: | | | | | |  | | | |  | | |
| **4. SAMPLING PROTOCOL** | | | | **No issues** | | | | **N/A** | | | |  | |  | |
| improper sample container | | | | inadequate tap flushing | | | | | |  | | | |  | | |
| aerator was not removed | | | | sample cooler unsanitary | | | | | |  | | | |  | | |
| autosensing faucet/swivel-type faucet | | | | other: | | | | | |  | | | |  | | |
| **5. TREATMENT PROCESS** | | | | **No issues** | | | | **N/A** | | | |  | |  | |
| treatment added or changed | | | | recent installation/repair | | | | | | |  | | |  | | |
| inadequate disinfection | | | | O&M procedures not followed | | | | | | |  | | |  | | |
| turbidity measurements out of range | | | | change in flow rates | | | | | | |  | | |  | | |
| interruption in treatment/power loss | | | | other: | | | | | | |  | | |  | | |
| **6. DISTRIBUTION SYSTEM** | | | | **No issues** | | | | **N/A** | | | |  | | |  |
| power loss | | | | pump station issues | | | | | | |  | | |  | | |
| standing water/debris in valve vault | | | | pump or valve failure | | | | | | |  | | |  | | |
| improper surge control | | | | improper operation of air-relief/air-vacuum valves | | | | | | |  | | |  | | |
| main breaks/leaks | | | | new mains or construction activity | | | | | | |  | | |  | | |
| illegal use of hydrants | | | | unprotected cross connection | | | | | | |  | | |  | | |
| captive air tank issues | | | | other: | | | | | | |  | | |  | | |
| **7. STORAGE TANKS** | | | | **No issues** | | | | | **N/A** | | | |  | |  |
| improper maintenance practices | | | | security issues | | | | | | |  | | |  | | |
| presence of dead animals/insects | | | | hatch not sealed | | | | | | |  | | |  | | |
| incorrect operation of level control/altitude valves | | | | deterioration or breaches in vent, screen, hatch, overflow | | | | | | |  | | |  | | |
| low disinfection residual | | | | other: | | | | | | |  | | |  | | |
| **8. SOURCE(S)** | | | | **No issues** | | | | **N/A** | | | |  | | |  |
| **Ground water, Surface Water or Spring Supply** | | | | | | | | | | |  | | |  | | |
| defective or damaged well cap/well seal | | | damaged well casing | | | | poorly maintained spring box | | | |  | | |  | | |
| floodwater, rapid snowmelt or run-off inundation | | | inadequate air gap | | | |  | | | |  | | |  | | |
| damaged or unscreened vent | | | potential source of contamination | | | |  | | | |  | | |  | | |
| missing or damaged grout seal | | | changes in sources | | | |  | | | |  | | |  | | |
| unprotected opening in pump/pump assembly | | | power outage | | | |  | | | |  | | |  | | |
|  | | | | | | | | | | |  | | |  | | |
| **Consecutive Connection/Water Hauler** | | | | | | | | | | |  | | |  | | |
| wholesale PWSID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |  | | |  | | |
| issues identified with water transport/delivery | | | | | | other: | | | | |  | | |  | | |
|  | | | | | |  | | | | |  | | |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Title: |  |
| Phone #: | Email: | Date: |  |

**Please return this form to: DEQ Public Water Supply Program, ATTN: RTCR Rule Manager, PO Box 200901, Helena, MT 59620-09901; Fax 406-444-1374; Phone 406-444-4400; email DEQRTCRLEVEL12@mt.gov**

|  |  |
| --- | --- |
| **Reserved for State** |  |
| 1. Assessment has been completed. (Y/N and Date) |  |
| 2. Likely reason for total coliform positives occurrence is established |  |
| 3. System has corrected the problem ( Y/N and Date) |  |
| 4. Was a Extension requested and/or granted? Rationale |  |
| 5. Name of State Reviewer: |  |