



Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Phone #: \_\_\_\_\_

Attn: \_\_\_\_\_

Purchase Order #: \_\_\_\_\_

Sample Collected by: \_\_\_\_\_

<b>For Lab Use Only: Verbal Results</b>
Name: _____
Date/Time: _____

Date Collected: \_\_\_\_\_

Time Collected: \_\_\_\_\_

Chlorine Residual: \_\_\_\_\_

Permit Number: \_\_\_\_\_

**Coliform:**

**Multiple Tube**

Analysis Requested:  Total  Total & Fecal  10 Tube  5,5,5  HPC  Quantitray

Send Copy To:  Kern County Health Dept.  State of California  Other: \_\_\_\_\_

Type of Sample  Drinking Water  Non-Drinking Water  Other: \_\_\_\_\_

Routine:  Repeat #: \_\_\_\_\_  Replacement  Other: \_\_\_\_\_

Sampling Point: \_\_\_\_\_

**For Laboratory use only**

Lauryl Tryptose Broth		Green Bile Broth		Fecal / E. Coli
Colilert				Circle One
24 hours	48 Hours	24 hours	48 hours	
1.		1.		1.
2.		2.		2.
3.		3.		3.
4.		4.		4.
5.		5.		5.

(Multiple Tube Dilution): \_\_\_\_\_

Total Plate Count/ml: \_\_\_\_\_

MPN/100 ml / Regular Media / or / Colilert: \_\_\_\_\_ A/P \_\_\_\_\_

MPN/100 ml / Fecal Coliform / or / E. Coli: \_\_\_\_\_ A/P \_\_\_\_\_

Lab No: \_\_\_\_\_

Date Received: \_\_\_\_\_

Time of Analysis: \_\_\_\_\_

Date/Time Completed: \_\_\_\_\_

100 mls Sample

Analyst's Initials: \_\_\_\_\_

Remarks: \_\_\_\_\_  
Comments on Report: \_\_\_\_\_

Relinquished by: (Signature)	Received by: (Signature)	Date:	Time:	Temperature:
Relinquished by: (Signature)	Received by: (Signature)	Date:	Time:	