



COLILERT PRESENCE/ABSENCE BACTERIOLOGICAL WATER SAMPLING RECORD

This form must be faxed to (867) 669-7517 or emailed to environmental_health@gov.nt.ca

Community Name: _____

*Ensure to complete all information in a line for each sample or your submission will not be accepted by Environmental Health Services.

Location of Sample	Treated or Raw	Sampled by	Tested by	Date/Time Sample Collected	Date/Time Sample Read	Coliform (Yellow)	E.coli (Fluorescent)	Comments
	<input type="checkbox"/> Treated <input type="checkbox"/> Raw					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Treated <input type="checkbox"/> Raw					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Treated <input type="checkbox"/> Raw					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Treated <input type="checkbox"/> Raw					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Treated <input type="checkbox"/> Raw					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Treated <input type="checkbox"/> Raw					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Operator Name: _____ Email: _____ 24/7 Telephone Number: _____