



RTCR Level 1 Assessment Guidance Template

331-569, March 2016

Send your
assessment to:

Eastern Region	16201 East Indiana Avenue, Suite 1500 Spokane Valley, WA 99216	Phone: 509.329.2100 Fax: 509.329.2104 Email: mark.steward@doh.wa.gov
Northwest Region	20425 72nd Ave. South, Suite 310 Kent, WA 98032-2358	Phone: 253.395.6750 Fax: 253.395.6760 Email: dw.nwro@doh.wa.gov
Southwest Region	PO Box 47823 Olympia, WA 98504-7823	Phone: 360-236-3030 Fax: 360-664-8058 Email: swro.coli@doh.wa.gov

Water System Name:	County:	Water System ID #:
Operator in Responsible Charge (ORC):	ORC Phone:	Water System Mailing Address:
ORC Address, City, State:		
Assessor Name:		
Assessor Address, City, State, Zip:		
Date(s) Assessment Completed:		

Your water system exceeded a treatment technique trigger for the Revised Total Coliform Rule. Assess the water system's condition and operation using this *Level 1 Assessment Template* as a guide.

Part A: Respond to each item below. Identify corrective actions taken to address the issue(s) found.

Part B: Summarize your findings and include an action plan with timetable for corrective actions not yet taken.

For parts A and B, include additional information (photos or other documentation) as needed to depict assessment findings and corrective actions that have been completed. All assessment elements listed in this template must be addressed in your assessment. Systems with multiple facilities such as wells or storage tanks may need to provide additional pages.

Within 30 days of learning of the treatment technique trigger, submit completed assessment documentation to [your regional office](#) and keep a copy in your water system files.

Part A: Assessment		Corrective action needed?	Corrective action(s) taken & date taken
1. Site and Sampling Protocol			
1a. Do you have a written coliform monitoring plan & sampling procedure that ensures samples are representative of the distribution system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
1b. Have there been any changes in sampling conditions or procedures that may have contributed to the treatment technique trigger? Describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
1c. Inspect the sampling sites:			
- Are the sampling locations free of potential sources of contamination?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	
- Are the sampling taps in good condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	
- Other: (describe) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Part A: Assessment		Corrective action needed?	Corrective action(s) taken & date taken
2. Distribution 2a. Do you have procedures in place to ensure proper maintenance of the distribution system, including: <ul style="list-style-type: none"> - Appropriate pipe replacement and repair procedures - Replacement and repair of other distribution system components - Regular flushing program - Routine vault inspections - Fully implemented cross connection control program - Maintain positive pressure in all parts of the distribution system 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
2b. Has there been any recently reported low pressure (<20 PSI) or complete loss of pressure in the distribution system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2c. Have there been any changes in distribution conditions or operations that may have contributed to the treatment technique trigger? Describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2d. Inspect the distribution system: <ul style="list-style-type: none"> - Are there any visible line breaks or leaks? - Are there any observed unprotected cross connections? - Is there any evidence of vandalism or other security breaches? - Other: (describe) _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Storage Facilities 3a. Does your water system have a water storage tank? <i>If no, skip to Section 4.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3b. Do you have procedures in place for periodic inspection and maintenance of the exterior and interior of each storage facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3c. Have there been any changes in storage conditions or operations that may have contributed to the treatment technique trigger? Describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3d. Inspect the storage facilities: <ul style="list-style-type: none"> - Does the tank have any cracks or other openings? - Is the reservoir roof free of any unprotected openings? - Is the access hatch constructed and sealed to keep contaminants out? - If there is an air vent on the storage tank, is it constructed to prevent the entry of contaminants? - Is the overflow line constructed to prevent contaminants from entering the tank? - If the overflow line discharges into a storm drain, to surface water, or directly into a sanitary sewer, is it protected by a proper air gap? - Is there any evidence of vandalism or other security breaches? - Other: (describe) _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	

Part A: Assessment		Corrective action needed?	Corrective action(s) taken & date taken
4. Source--Groundwater	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4a. Does your water system have a well or spring? If no, skip to Section 6.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4b. Do you comply with Sanitary Control Area requirements (WAC 246-290-135(2))?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4c. Have there been any changes in source conditions or operations that may have contributed to the treatment technique trigger? Describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4d. Inspect the source facilities: - Is the sanitary control area free of all potential sources of contamination? - Is the wellhead or spring box above grade with no potential for flooding? - Is the pressure tank water logged? - Is the well cap sealed and watertight, and the well casing free of unprotected openings? - (For springs) Is the spring box (structure, hatch, and overflow) free of any unprotected openings? - Other: (describe) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Treatment--Groundwater	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5a. Is any source continuously treated with a disinfectant ? If no, skip to Section 6.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5b. Do you have procedures in place for proper operation and maintenance of disinfection treatment facilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5c. Have there been any changes in treatment equipment or process that may have contributed to the treatment technique trigger? Describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5d. Inspect the treatment facilities: - Is the treatment system operating properly? - Is there any evidence of vandalism or other security breaches? - Other: (describe) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Source—Surface Water Supply (watershed)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6a. Does your water system have a surface water supply? If no, skip to Section 8.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6b. Do you comply with Watershed Control Program requirements (WAC 246-290-135(4))?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6c. Have there been any changes within the watershed or in raw water conditions that may have contributed to the treatment technique trigger? Describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Part A: Assessment		Corrective action needed?	Corrective action(s) taken & date taken
6d. Inspect the surface water intake/headworks: - Is there evidence of problems at the intake? - Is there evidence of vandalism or other security breaches at the intake? - Other: (describe) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Treatment—Surface Water			
7a. Do you have procedures in place for proper operation and maintenance of surface water treatment facilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7b. Have there been any changes in treatment equipment or process that may have contributed to the treatment technique trigger? Describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7c. Inspect the treatment facilities: - Is the treatment system operating properly? - Is there any evidence of vandalism or other security breaches? - Other: (describe) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Other assessment activities (describe):			

Part B. Assessment Summary and Action Plan with Timetable for corrective actions not yet taken

ASSESSOR: CHECK HERE if you did not identify any issues that may have directly or indirectly caused or contributed to entry of coliform bacteria into the system.

Corrective Actions Completed: ASSESSOR: Summarize the issues found and the corrective actions that have been completed and date completed

Describe issue found	Describe corrective action taken and date completed

Corrective Actions Not Completed: ASSESSOR: Describe the issues for which corrective actions have not yet been completed. **Provide an action plan with timetable for completion.**

Describe issue found	Describe planned corrective action and timetable for completion.

Print Name of Assessor: _____ Signature of Assessor: _____ Date: _____

OFFICE OF DRINKING WATER USE ONLY

Regional Office Reviewer: _____ Date of Review: _____

Assessment sufficient? Yes No

Likely cause determined? Yes No

Sanitary defect(s) identified? Yes No

Corrective actions completed? Yes No

Corrective action plan included? Yes No

Corrective action plan approved? Yes No

Comments: