



Bacteriological Report

I. PWS INFORMATION: Refer to your DEP Coliform Sampling Plan to help complete the PWS information and DEP Approved Sample Site information sections below.

PWS ID #: 2032000 PWS Name: Blackstone Water Department City/Town: Blackstone Class: COM [X] NTNC [] TNC []

II. ANALYTICAL INFORMATION: Refer to your MassDEP state lab certificate for proper Lab MA Cert.# and certified methods.

Primary Lab MA Cert.#: M-CT008 Primary Lab Name: Microbac Laboratories, Inc. - Dayville Subcontracted?(Y/N): N
Analysis Lab MA Cert.#: M-CT008 Analysis Lab: Microbac Laboratories, Inc. - Dayville

[X] Original Report [] Resubmitted Report [] Confirmation Report (f) Reason for Resubmission: [] Resample [] Reanalysis [] Report Correction (2) Collection Date of Original Sample:

Table with 5 columns: TC Method, E. Coli Method, Enterococci Method, Fecal Coliform, HPC Method. Row 1: 23 B (Colliert Quanti-Tray)-2004, 23 B (Colliert Quanti-Tray)-2004, , , . Lab Sample Notes:

Table with 12 columns: Sample Type, Location Code #, DEP Approved Sample Location, Total Coliform Result, E. Coli or Fecal Result, Chlorine Result mg/L, HPC Result # cfu/ml, Collection Date, Time, Analysis Date, Time, Collected By, Lab Sample ID #. Rows 1-9 contain data for various locations like Fire Station #2, Mill River Road, etc.

1 DEP Sample Type, Location Code#, and DEP Approved Sample Site Location must correspond to the sample information on your DEP Total Coliform Sampling Plan
2 SWTR systems: HPC samples shall be taken at the same distribution sites and at the same time as total coliform, whenever chlorine residual is not detected at the sample site.
3 Sample Type: RS-Routine Distribution Sample,RO-Original Site Repeat,UR-Upstream Repeat,DR-Downstream Repeat,AR-Additional Repeat,RW-Raw Water,PT-Plant Tap,SS-Special Sample
4 Report as #/100mL,P (present),A (absent), or Too Numerous To Count: TNTC-I(Invalid) or TNCT-P(present).
5 Collect appropriate number of repeat samples within 24 hours of laboratory notification for coliform-positive or invalid samples. Notify DEP of any routine or repeat E.Coli or fecal positive results by the end of the business day.

I declare, under penalties 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 extent of my knowledge. Laboratory Authorized Signature and Date: [Signature] 11/06/2024

DEP Review Status: [] Accepted [] Disapproved Review Comments:

