NEW JERSEY DEPARTMENT OF ENVIRONMENTAL PROTECTION
Division of Water Supply and Geoscience
Bureau of Safe Drinking Water
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REVISED TOTAL COLIFORM RULE (RTCR) LEVEL 1 ASSESSMENT FORM

Public Ground Water Systems Serving **Less than or Equal (<)** 1000 Persons

The water system owner or designee must review and evaluate all the elements for possible sanitary defects. Indicate *Yes, No, or N/A* if the element is not applicable to the water system. **All sections of this form must be completed, and all applicable checkboxes must be marked**.

- **The supplier of water (water system owner or licensed operator of record) is required to submit the completed form within thirty (30) days** after learning its system has exceeded a treatment technique trigger (not from receipt of the Bureau of Safe Drinking Water's letter) in accordance with N.J.A.C. 7:10-5.8 (b). The completed form can be sent via email to watersupply@dep.nj.gov and include the "Water System Name", "PWSID" (e.g., NJ0101001) and "Level 1 Assessment" in the subject line.
- Attach additional pages and include any supporting documentation (e.g., invoices, estimates, receipts) where necessary.
- When completing this form refer to the water system's records (e.g., operation and maintenance records, tank inspections reports, and information related to the physical condition of the water system components) **from at least one year prior to the assessment date.**
- When determining appropriate corrective actions, evaluate and compare incident dates identified during the assessment to the RTCR sampling trigger dates.
- *If the supplier of water fails to submit a completed assessment and supporting documentation in their entirety, the water system may be subject to a treatment technique violation, public notification requirements and associated enforcement actions.*

For more information on the Revised Total Coliform Rule, visit our website at http://www.nj.gov/dep/watersupply/dws-sampreg.html.

PWSID#:	**System Name:**	**Site Visit Date: ***
System Type: ☐ Community Water System ☐ Non-transient Non-community System ☐ Transient Noncommunity		
Month/Year of Level 1 Treatment Technique Trigger: _____/_____		

***Site Visit Date is the day when the on-site inspection was completed in its entirety.**

PWSID #: _____ System Name: _____

1	General	Sanitary Defect Identified
1.1	Has there been vandalism and/or unauthorized access to the facilities within the last year?	☐ **Yes** ☐ No
1.2	Have there been any interruptions to electrical power within the last year?	☐ **Yes** ☐ No
1.3	Are there any visible signs of contamination from animals or insects around the facilities (e.g., wellhead, tanks, lab, etc.)?	☐ **Yes** ☐ No
1.4	Other comments on the general water system information:	

2	Source	Sanitary Defect Identified
2.1	List the well(s) in operation within 7 days prior to and/or during the sampling event (e.g., WL001001): _____ _____ _____ _____ _____ _____	
2.2	Were any new, emergency, or inactive wells in operation or introduced into the system within 7 days prior to and/or during the sampling event?	☐ **Yes** ☐ No
2.3	Were any interconnection(s) or alternate source(s) of water in operation/ introduced into the system within 7 days prior to and/or during the sampling event?	☐ **Yes** ☐ No
2.4	Are there any abandoned well(s) on the property that are improperly sealed?	☐ **Yes** ☐ No
2.5	Is there visible damage to the well(s)? (e.g., well cap broken, wellhead electrical wires exposed)	☐ **Yes** ☐ No
2.6	Is the wellhead(s) less than 12” above ground level?	☐ **Yes** ☐ No
2.7	Is there evidence of standing water near the wellhead(s)?	☐ **Yes** ☐ No
2.8	Is the wellhead(s) in a pit?	☐ **Yes** ☐ No
2.9	Is the area around the wellhead(s) prone to flooding?	☐ **Yes** ☐ No
2.10	Is the wellhead(s) open to unauthorized access?	☐ **Yes** ☐ No
2.11	Have there been any spill(s)/ or contaminant(s) released nearby within the last year?	☐ **Yes** ☐ No
2.12	Has any repair(s)/work been performed to the well(s) or components within the last year?	☐ **Yes** ☐ No
2.13	Is there a septic system within 50 feet of the well(s)? Remember to evaluate other properties adjacent to the wellhead.	☐ **Yes** ☐ No

PWSID #: _____ System Name: _____

3	**Treatment** ☐ No treatment If no, move to Section 4.	**Sanitary Defect Identified**
3.1	Have there been any interruptions in the treatment processes within the last year? (e.g., disruptions in chemical feed, disinfection, treatment bypass, etc.)	☐ **Yes** ☐ No
3.2	Has there been any repair of treatment equipment within the last year?	☐ **Yes** ☐ No
3.3	Were there any changes in the treatment process within the last year? (e.g., Addition or removal of a treatment process, change in chemical or dosage, etc.)	☐ **Yes** ☐ No
3.4	Provide the most recent date that the UV light bulb was changed: _____ ☐ N/A	

4	**Distribution System**	**Sanitary Defect Identified**
4.1	System pressure: Is there evidence that the system experienced low (< 20 PSI) or negative pressure within the past three months?	☐ **Yes** ☐ No
4.2	Are there any cross connections without a backflow preventor present? (e.g., irrigation system, fire suppression, industrial process water, pools, etc.)	☐ **Yes** ☐ No ☐ N/A
4.3	Have there been plumbing repairs or additions within the last year (e.g., bathroom sinks, kitchen sinks)?	☐ **Yes** ☐ No
4.4	Provide the last maintenance/service date for all pumps (e.g., booster stations, well pumps, etc.) within the distribution system: _____ ☐ N/A	
4.5	Is there evidence of intentional contamination in the distribution system?	☐ **Yes** ☐ No
4.6	Have there been sites/areas with low or non-detectable chlorine residual within the past 3 months?	☐ **Yes** ☐ No ☐ N/A
4.7	Is there a raw water tap missing?	☐ **Yes** ☐ No
4.8	Has there been nearby hydrant flushing?	☐ **Yes** ☐ No

5	**Storage/Pressure Tanks** *Address all storage facilities. Storage facilities questions pertain to all types of storage reservoirs (e.g., below ground, above ground, elevated, indoor, outdoor, opened, closed, gravity, pneumatic, etc.). If more than one storage facility exists, provide responses for each unique storage facility.*	**Sanitary Defect Identified**
5.1	Provide the number and type of storage/pressure tanks present at the system: _____	
5.2	Are storage facilities open to unauthorized persons?	☐ **Yes** ☐ No
5.3	Are there observed leaks or physical deterioration of the tanks?	☐ **Yes** ☐ No
5.4	Is there evidence of vandalism or intentional contamination of the storage tanks within the last year? Has there been evidence of unauthorized access?	☐ **Yes** ☐ No
5.5	Provide last tank inspection/service date(s): Tank 1: _____ Tank 2: _____	
5.6	Are there other observations of tank construction/operation that could contribute to the positive sample results?	☐ **Yes** ☐ No

PWSID #: _____ System Name: _____

6	**Sampling** *The questions in this section are intended for the assessor to answer. You may contact your lab or reference your chain of custody form to assist in completing this section.*	**Sanitary Defect Identified**
6.1	Check this box to certify total coliform samples were collected according to the RTCR Sampling Plan. ☐	
6.2	Have conditions changed at the sample site since the last sample collection?	☐ **Yes** ☐ No
6.3	Was the positive sample taken from an outside spigot or tap?	☐ **Yes** ☐ No
6.4	Was the positive sample taken from a faucet that is able to swivel/rotate?	☐ **Yes** ☐ No
6.5	Was the positive sample taken from an automatic faucet?	☐ **Yes** ☐ No
6.6	Did the sample tap(s) have a point of use treatment on it? (e.g., filter on faucet)	☐ **Yes** ☐ No
6.7	Are there any visible indicators of unsanitary sampling tap conditions?	☐ **Yes** ☐ No
6.8	Did the sample collector fail to flush the tap prior to sample collection?	☐ **Yes** ☐ No
6.9	Did the sample collector fail to remove the aerator before sample collection?	☐ **Yes** ☐ No
6.10	Was the sample tap leaking or broken at the time of sample collection?	☐ **Yes** ☐ No
6.11	Check this box to certify total coliform samples were collected/ analyzed by a NJDEP certified laboratory. ☐	

7	**Summary**

If any boxes were checked **"Yes"**, using the table below, **describe all issues found during the assessment and summarize all corrective actions, including completed and proposed timeframes.** Attach any supporting documentation if applicable regarding implemented corrective actions. Within 14 days of completing any remaining corrective actions, complete and submit the Corrective Actions Completion Certification (WSO-CA-01).

Sanitary Defect(s) Identified (Check all that apply):

☐ **General** ☐ **Source** ☐ **Treatment** ☐ **Distribution System/Pumps** ☐ **Storage Tanks** ☐ **Sampling**

☐ If no sanitary defects were found during the assessment, check this box to certify that the assessment was completed in accordance with the EPA *RTCR Assessments and Corrective Actions Guidance Manual.*

Sanitary Defect Identified	Corrective Action	Corrective Action Completion Date or Proposed Completion Date
e.g., 2.6 Wellhead is below 12" ground level	***e.g., Licensed Professional to raise well head 12" above ground level***	***e.g., completed June 20, 2023***

PWSID #: System Name:

If all corrective actions were completed and shock chlorination was performed, provide the details below:
**Prior approval from the Bureau of Safe Drinking Water is required prior to disinfecting a source (shock chlorination) as a single corrective action (i.e., not following repairs/other corrective actions based on findings) if no sanitary defects are identified and addressed under the assessment. Disinfection must be conducted in accordance with N.J.A.C. 7:10-11.6, 7, &10 for community water systems and N.J.A.C. 7:10-12.11 for noncommunity water systems.*

Date of chlorination and party that conducted the chlorination	Product Used	NSF/ANSI 60 certified	Residual at POE	Residual at furthest point in Distribution System	Contact time (number of hours)	Flush Date
		☐ Yes ☐ No				
		☐ Yes ☐ No				

Certification: I certify under penalty of law that I am the person authorized to complete a Level 1 Assessment form, and the information contained herein is true, accurate and complete to the best of my knowledge and belief. I certify that I have filled out and/or reviewed this form, as the approved party or in the presence of the approved party, in its entirety and failure to complete and submit this form will result in the issuance of a treatment technique and state violations. I acknowledge, upon issuance of a violation, I will be referred to Compliance and Enforcement or the County Health Department for penalties and enforcement action. I hereby certify that the Corrective Actions listed in Section 7 indicated as completed have been completed as applicable and were completed in accordance with corresponding plans, specifications, other supporting information, and applicable state and federal regulations.

Water System Owner/ Licensed Operator of Record if applicable:

Contact Name:	
Signature:*	**Date:**
Contact Email:	**Contact Phone Number:**
This must be signed and dated by the water system owner/licensed operator of record, or the assessment is considered incomplete, and the system will incur a treatment technique violation per 40 CFR 141.860(b).	

Approved Party if not completed by the Water System Owner:

Completed by:	**Certification/License #:**
Signature:*	**Date:**
Email:	**Phone#:**
If an approved party conducted the assessment, this must be signed and dated by the approved party, or the assessment is considered incomplete, and the system will incur a treatment technique violation per 40 CFR 141.860(b).	