APPLICATION FOR PUBLIC WATER TESTING

2020 INSPECTION FEES: The total fee is determined by the laboratory fee(s) plus $125.00 collection fee (ALL FEES ARE NON-REFUNDABLE)

Applicant Name _____________________________

Mailing Address ________________________________________________________________

City____________________________  State: __________________  Zip: _________________

Phone #: _______________________________  Fax #: ________________________________

Email Address: _________________________________________________________________

How would you like to receive your evaluation report?      Mail      Fax      Email

If you would like additional copies of the evaluation report sent to another party, please provide contact information on a separate sheet.

LOCATION OF REQUESTED SAMPLE (If different than above)

Current Owner’s Name______________________________________________________________

Property Address ________________________________________________________________

City____________________________  Township ________________________________

Phone #: _______________________________  Fax #: ________________________________

Email Address: _________________________________________________________________

Directions to property:
__________________________________________________________________________________

PUBLIC WATER SYSTEM #: ______________________________

PARAMETER TO BE TESTED: (please circle)

Coliform Bacteria (Positive/Negative):  Y  N  LABORATORY FEE:  $17.00

Nitrate:  Y  N  LABORATORY FEE:  $12.00

Iron:  Y  N  LABORATORY FEE:  $12.00

Laboratory Fees plus $125.00 Collection Fee = Total Fee      TOTAL FEE: _____________
The applicant understands the water system rules require the water system to be flushed for a minimum of 10 minutes prior to taking the water sample. A faucet or spigot must be turned on to take the sample. The applicant is responsible for ensuring that the water faucet/spigot are in good condition and turned off to their satisfaction upon leaving. The Health Department is not responsible for faulty faucets or drains.

If for any reason the appointment needs to be cancelled or rescheduled, you must call at least 24 hours prior to the originally scheduled appointment.

Applicant______________________________________________ Date________________

FOR OFFICE USE ONLY

Driver’s License #: ____________________

1st WS Receipt #: ___________________________ Date Paid: ________________

Additional WS Receipt #: ___________________________ Date Paid: ____________

Additional WS Receipt #: ___________________________ Date Paid: ____________

Additional WS Receipt #: ___________________________ Date Paid: ____________

Appointment Date & Time: _______________________________________________________

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<thead>
<tr>
<th>Location</th>
<th>Inspector</th>
<th>Date</th>
<th>AR#</th>
<th>Results</th>
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<tbody>
<tr>
<td>1st Sample: __________</td>
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<td>3rd Sample: __________</td>
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Type of well: __________________________ Condition of well: __________________________

Additional Results/Comments: _______________________________________________________
______________________________________________________________________________