



NEW JERSEY DEPARTMENT OF ENVIRONMENTAL PROTECTION
 Division of Water Supply and Geoscience
 Bureau of Safe Drinking Water
 Mail Code 40104Q – P.O. Box 420
 Trenton, New Jersey 08620
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REVISED TOTAL COLIFORM RULE LEVEL 2 ASSESSMENT FORM
 Public Ground Water Systems Less than or Equal to 1000 Persons

An approved party 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. If a potential sanitary defect is identified, provide a description of the defect, corrective actions taken or proposed, and the date that the corrective action was completed or proposed to be completed. Attach additional pages (copy of the water system's most recent RTCR Sampling Plan, and include any supporting documentation, e.g. invoices, estimates, receipts) where necessary. The supplier of water is required to submit the completed form within thirty (30) days after learning your 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. 7:50(b). The completed form can be sent by mail or email via: watersupply@dep.nj.gov. Failure to submit a completed assessment and supporting documentation in their entirety, as indicated above, may result in the issuance of a treatment technique violation.

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

PWSID#:	PWS Name:	Site Visit Date:*
System Type: <input type="checkbox"/> CWS <input type="checkbox"/> NTNC <input type="checkbox"/> TNC		
Level 2 Trigger <input type="checkbox"/> E. coli MCL violation <input type="checkbox"/> Second Level trigger in a rolling 12 month period <input type="checkbox"/> Voluntary Level 2 Assessment (including request for sample reduction)		
Month/Year of Treatment Technique Trigger: _____		
Name of State Approved Party: _____		Certification/License #: _____
<input type="checkbox"/> Licensed Operator <input type="checkbox"/> Licensed Professional Engineer <input type="checkbox"/> Licensed Well Driller <input type="checkbox"/> Licensed Pump Installer <input type="checkbox"/> State/County Official		
<input type="checkbox"/> Most recent RTCR Sampling Plan is attached.		

*Site Visit Date is the day when the site inspection was completed.

Approved Party:

Certification: I certify under penalty of law that I am the person authorized to perform a Level 2 Assessment and the information contained herein is true, accurate and complete to the best of my knowledge and belief. I certify that I was present as the Sections indicated below were evaluated and filled in their entirety. Failure to comply with N.J.A.C. 7:50(d) may result in the issuance of a state violation and being referred to Compliance and Enforcement for penalties and enforcement action.

Completed by:	Certification/License #:
Signature:*	Date:
Email:	Phone#:
Sections I certify I assessed: <input type="checkbox"/> General <input type="checkbox"/> Source <input type="checkbox"/> Treatment <input type="checkbox"/> Distribution <input type="checkbox"/> Storage/Pressure Tanks <input type="checkbox"/> Sampling <input type="checkbox"/> Summary	
*This must be signed and dated by an approved party, or the assessment is considered incomplete and the system will incur a treatment technique violation per 40 CFR 141.860(b).	

PWSID: System Name:

Water System Owner or Water System's Licensed Operator of Record (i.e. Supplier of Water):

Certification: I certify under penalty of law that I am the person authorized to complete a Level 2 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 this form, in the presence of the approved party, 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 for penalties and enforcement action.

Name:		<input type="checkbox"/> I certify that the approved party was on site the date indicated in the site visit field.	
Signature:		Date:	
Contact Name:	Contact Email:	Contact Phone#:	
*This must be signed and dated by the water system owner or 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).			

Licensed Operator (if applicable):

Name:		<input type="checkbox"/> I certify that the approved party was on site the date indicated in the site visit field.	
Signature:		Date:	
Contact Email:		Contact Phone#:	

PWSID: System Name:

1	General		Description of Defect and Corrective Action Taken/Proposed	Date Corrected/Proposed	For official State use only**
1.1a	Is the water system required to have a licensed operator of record? If yes, provide the name and license number of the licensed operator of record.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
1.1b	If yes to question number 1.1a, provide a copy of the licensed operator of record's log for the month prior to and in which the RTCR was triggered.	<input type="checkbox"/> N/A			
1.2	Has there been vandalism and/or unauthorized access to any water system facilities? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
1.3	Has there been any community illness suspected of being waterborne? (e.g., The public health official has determined an outbreak occurred.) If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
1.4	Has there been any customer complaints of taste or odor problems? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
1.5a	Does the system have a septic system? If yes, provide the details listed.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last time the system was pumped: Date: _____ Date of last inspection: _____ Distance between septic & well(s): _____		
1.5b	Is the distance between the septic and well less than the allowed distance according to N.J.A.C 7:10-11.7(b)(2) and/or does not meet building specifications for wells below the allowable limit? If yes, provide the next steps to reach compliance.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
1.6	Is the septic system routinely maintained or inspected? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
1.7	Was maintenance performed or repairs made to the septic or sewer system recently? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Date(s) of service:		
1.8	Have there been any interruptions to electrical power? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s) of incident:		

PWSID System Name

1.9	Other comments on the general water system information:			
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2	Source	Description of Defect and Corrective Action Taken/Proposed	Date Corrected/Proposed	For official State use only**
2.1	How many wells were in operation within 7 days prior to and/or during the sampling event? Provide the well permit number(s). If there is no well permit number, provide the water state facility code(s) instead e.g. WL001001	# In Use:		
2.2	Were any new, emergency, or inactive wells in operation/introduced into the system within 7 days prior to and/or during the sampling event? If yes, provide a description including the facility code(s), e.g. WL001001, and well permit numbers	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2.3	Are there any abandoned wells on the property? If yes, provide a number of wells and their location.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2.4	Regarding 2.3, were all of these wells properly decommissioned per N.J.A.C. 7:9D, Sub. 18? If no, provide a corrective action	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
2.5	Is there evidence of standing water near the wellhead(s)? If yes, provide a corrective action	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2.6	Is the sanitary seal(s) intact? If no, provide a corrective action	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2.7	Is the well cap(s) vented? If no, provide a corrective action	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
2.8	Is the vent(s) screened? If no, provide a corrective action	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
2.9	Is the wellhead(s) flush to grade or under 12" above grade? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2.10a	Is the wellhead(s) in a pit? If yes, provide a description	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2.10b	Is the pit the wellhead(s) is dry? If no, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		

PWSID:	<input type="text"/>	System Name:	<input type="text"/>		
2.11a	Is the wellhead(s) secured from unauthorized access? If no, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2.11b	Is the wellhead(s) physically protected? If no, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2.12	Have there been any sewer overflows, chemical spills, contaminants, or other disturbances nearby? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2.13	Has any recent repair/work been performed to the source(s) or its components? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s) of service:		
2.14	Are there any other observations of well construction/operation that would bear on observed positives? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2.15	Other Comments on the source including identification of proposed corrective actions:				

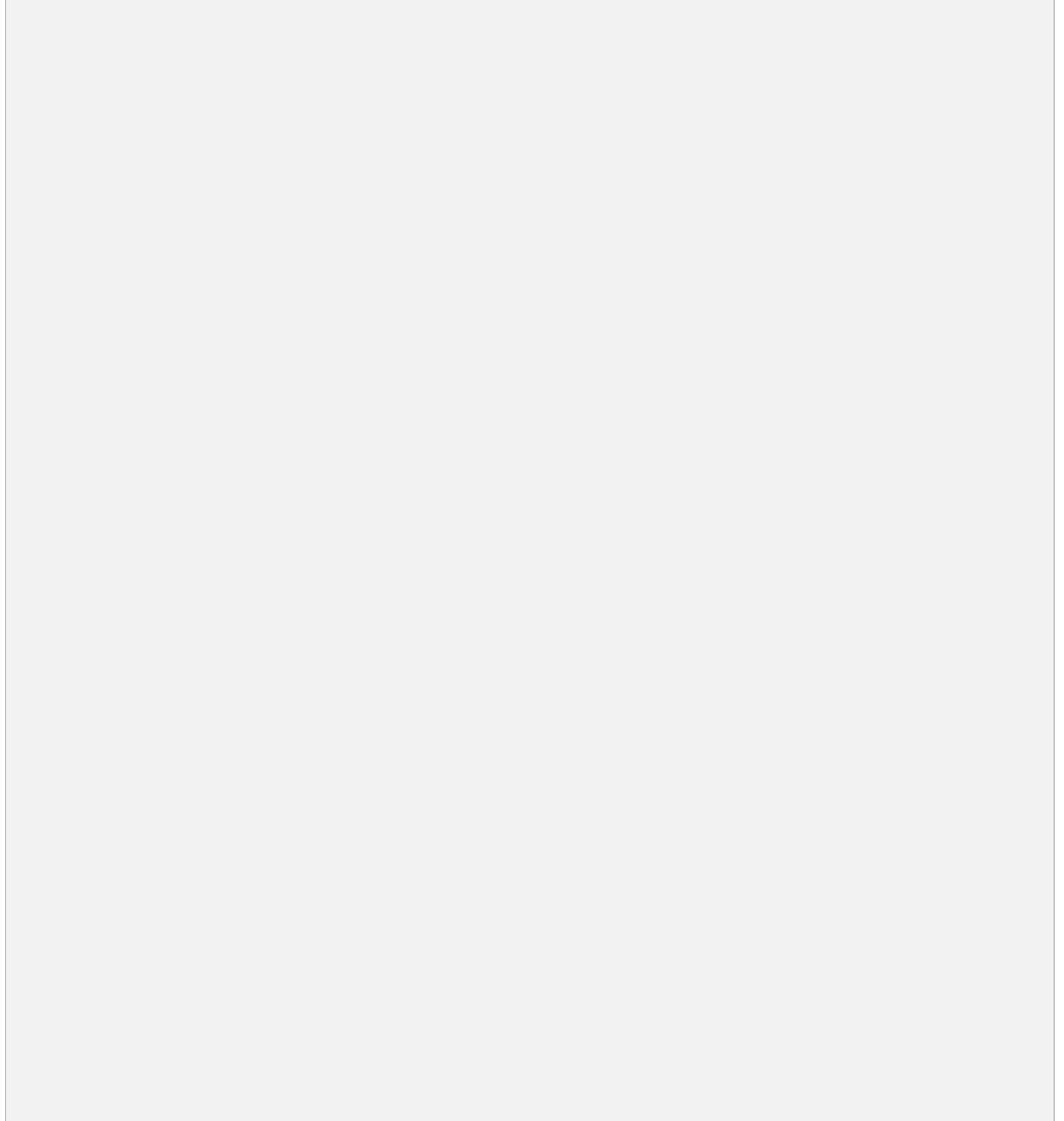
3	Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No If no, move to Section 4.	Description of Defect and Corrective Action Taken/Proposed	Date Corrected/Proposed	For official State use only**
3.1	Have there been any interruptions in the treatment process (e.g. lapses in chemical feed, disinfection)? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s) of incident:	
3.2	Have treatment devices been maintained and operating normally? If no, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3.3	Has there been any recent installation or repair of treatment equipment? If yes, provide a description including dates.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3.4	Were there any recent changes in the treatment process? (e.g. addition of a process, change in chemical or dosage) If yes, provide a description including dates.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3.5	Is disinfection the last treatment process in the system? If no, provide a description. This should be consistent with the treatment train drawn below.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		

PWSID System Name

3.6	What is the chlorine residual measured at the entry point for the day the water left the plant prior to testing TC and/or EC positive in the distribution system? (Base on the system's average time of travel.)	<input type="checkbox"/> N/A	Total: _____ Free: _____ Date: _____		
3.7	What is the UV intensity measured for the day the water left the plant prior to testing TC and/or EC positive in the distribution system?	<input type="checkbox"/> N/A	Value: _____ Date: _____		
3.8a	Were the flow rates above the rated capacity? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
3.8b	Provide the flow rate capacity or attach the permit showing the flow rate capacity.	<input type="checkbox"/> N/A	<input type="checkbox"/> Attached Capacity: _____		
3.9	Were there any failures to meet the CT requirements? If yes, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
3.10	Is there any treatment installed that is currently not in use and, if so, why?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
3.11	List the last treatment service date for all treatment units and by whom:	<input type="checkbox"/> N/A	Device: _____ Date: _____ Servicer: _____		
3.12	List the last backwash date for all treatment units:	<input type="checkbox"/> N/A	Device: _____ Date: _____		
3.13	Is there any point of use treatment? If yes, provide the type, location, installation date, and specifications.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type: _____ Location: _____ Installation Date: _____ Specifications: _____		
3.14	Is the point of use device routinely maintained and inspected? Provide the date it was last maintained and by whom.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____ Servicer: _____		

PWSID System Name

3.15 Sketch and label the water system's Treatment Train that consists of all units and processes in order from the well to the point of entry.*Attach additional sheets if necessary.



3.16 Other comments on the treatment system including proposed corrective actions:

PWSID System Name

4	Distribution	Description of Defect and Corrective Action Taken/Proposed	Date Corrected/Proposed	For official State use only**
4.1	Was the sample collected in a hydraulically isolated area of the distribution system (e.g. separate pressure zone, deadend)? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4.2	System pressure: Is there evidence that the system experienced low (<20 psi) or negative pressure? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date(s) of Incident:	
4.3	Is there an irrigation system served by the potable source? If yes, provide the location	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4.4	Is there a fire suppression system served by the potable source? If yes, provide the location	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4.5	Were any cross connections identified? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4.6	Are backflow prevention devices present? If yes, provide a description and where. If no, provide a corrective action. (Required if system has an irrigation or fire suppression system served by the potable source.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
4.7	Regarding 4.5, have backflow prevention device(s) been operational and maintained? If yes, provide the most recent date of maintenance and by whom.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
4.8	Have there been any water main repairs, removals, or additions? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4.9	Were any leaks or main breaks discovered during the investigation? If yes, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4.10	Is there any evidence of intentional contamination in the distribution system? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4.11	Are there areas where it is difficult to maintain a residual (e.g. dead-ends)? If yes, provide a description	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		

PWSID		System Name			
4.12	Have there been any operating issues with control valves (i.e. Pressure Reducing Valves, Altitude)? If yes, provide a description and a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
4.13	Most recent pump in distribution system (e.g. booster pump) maintenance/service date:	<input type="checkbox"/> N/A			
4.14	Other comments on the distribution system including proposed corrective actions:				

5	Storage/Pressure Tanks		Description of Defect and Corrective Action Taken/Proposed	Date Corrected/Proposed	For official State use only**
5.1	How many storage tanks are in the system?	# In Use:	Identify tank(s) and the type of tank(s):		
5.2	Are the facilities secured from unauthorized access? If no, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
5.3	Do the access openings have proper gaskets and/or seal tightly? If no, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
5.4	Was there any observed leaks or physical deterioration (e.g. rust) of the tanks? If yes, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
5.5	Could the physical condition of the tanks be a source of contamination including leaks? If yes, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
5.6	When was the most tank inspection(s) date(s)?	<input type="checkbox"/> N/A	Tank: _____ Date of last inspection: _____ Tank: _____ Date of last inspection: _____		
5.7	Was the tank analyzed for total coliform/E. coli? If yes, attach lab report(s) and provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
5.8	Is the bladder in the pressure tank waterlogged? If yes, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			

PWSID System Name

5.9	Has there been any evidence of vandalism or intentional contamination at the storage tank(s)? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
5.10	Did the pressure tanks deviate from normal operating pressure? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
5.11	Other comments on the storage system including proposed corrective actions:				

6	Sampling		Description of Defect and Corrective Action Taken/Proposed	Date Corrected/Proposed	For official State use only**
6.1	Were the Total Coliform samples collected by a NJDEP certified laboratory? If no, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
6.2	Were the samples collected according to the RTCR Sampling Plan? If no, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
6.3	Was the sampling plan revised prior to the collection of the positive samples? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
6.4	Have conditions changed at the sample site since last sample collection? If yes, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
6.5	Have there been any additional analytical samples, such as specific, elective, and/or investigatory, collected, including source samples which were positive? If yes, provide a description and attach the corresponding lab reports.	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, attach the corresponding lab reports.		
6.6	Were there any visible indicators of unsanitary conditions? If yes, provide a description and a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No			

PWSID	System Name			
6.7	What is the condition of the tap(s)? (Use the boxes below)			
6.7A	<input type="checkbox"/> Clean/sanitary			
6.7B	<input type="checkbox"/> Corroded			
6.7C	<input type="checkbox"/> Unclean/unsanitary			
6.7D	<input type="checkbox"/> Recently replaced			
6.7E	<input type="checkbox"/> Improper construction			
6.7F	<input type="checkbox"/> Leaking/Broken			
6.7G	<input type="checkbox"/> No problems seen			
6.7H	<input type="checkbox"/> Other			
6.8	Was the sample tap leaking or broken? If yes, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6.9	Was the sample taken from an outside spigot or tap? If yes, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6.10	Was the sample taken from a swivel faucet? If yes, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6.11	Did the sample tap have a point of use treatment device on it? If yes, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6.12	Were Standard Operating Procedures followed during Total Coliform samples collection and handling? If no, provide a description and documentation from laboratory or sample collector.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6.12 A(1)	Were you present when the sampling occurred? If yes, provide a yes or no response to 6.12A(2).	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6.12A (2)	Was the aerator removed? If no, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
6.12B	Was the sample site flushed prior to sample collection? If no, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6.12C	Were appropriate sample collection techniques followed? (This includes eliminating water splashing from sink and sampler not touching the inside of the sample bottle.) If no, provide a description and documentation	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6.12D	Was the laboratory contacted for this assessment to ensure all laboratory quality control processes were followed? If no, provide a description.	<input type="checkbox"/> Yes <input type="checkbox"/> No		

PWSID		System Name			
6.12E	If the laboratory was contacted, provide the date and name of person contacted:	<input type="checkbox"/> N/A			
6.13	Is there potential for hot water to enter the sample tap? If yes, provide a corrective action.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
6.14	Other comments on sampling including proposed corrective actions:				

*The system must submit their Revised Total Coliform Rule Sampling Plan with this Level 2 Assessment.

7	Summary																					
<p>Identify and summarize the issues that were found during the assessment. Using the selection below, check all that apply and briefly summarize the corrective action performed as a result of these findings</p> <p><u>Describe all issues found and corrective actions, including completed and proposed timeframes. Please attach all documentation (i.e. lab reports, chain of custody forms, repair receipts, photographs), regarding implemented corrective actions.</u></p> <p>Sanitary Defect(s) identified:</p> <p><input type="checkbox"/> Source <input type="checkbox"/> Treatment <input type="checkbox"/> Distribution System <input type="checkbox"/> Storage Tanks/Pumps <input type="checkbox"/> Sampling</p> <p><input type="checkbox"/> If no sanitary defects were found during the assessment, check this box to certify that the assessment was completed in accordance with the EPA/ATCR Assessments and Corrective Actions Guidance Manual.</p> <p>If shock chlorination was performed, provide the details below*:</p> <table border="1"> <thead> <tr> <th>Date of chlorination and party that conducted the chlorination</th> <th>Product Used</th> <th>NSF/ANSI 60 certified Y or N</th> <th>Residual at POB</th> <th>Residual at furthest point in Distribution System</th> <th>Contact time (number of hours)</th> <th>Flush Date</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table> <p><i>*Prior approval from the State 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. 7:1-11.6, 7, &10 for community water systems and N.J.A.C. 7:10-12.11 for noncommunity water systems.</i></p>		Date of chlorination and party that conducted the chlorination	Product Used	NSF/ANSI 60 certified Y or N	Residual at POB	Residual at furthest point in Distribution System	Contact time (number of hours)	Flush Date														
Date of chlorination and party that conducted the chlorination	Product Used	NSF/ANSI 60 certified Y or N	Residual at POB	Residual at furthest point in Distribution System	Contact time (number of hours)	Flush Date																

PWSID System Name

Sanitary Defect Identified	Corrective Action	Corrective Action Completion Date or Proposed Completion Date	Owner Initials	Licensed Operator Initials	Approved Party Initials

NJDEP USE ONLY

**Only document insufficient and/or inadequate responses in the "For Official State Use Only" column using an "X" and provide additional information in the comment section below.

PWSID#: _____ Date of Level 2 Trigger: _____ NJEMS RTC#: _____

NJDEP Reviewer: _____ Signature of Reviewer: _____ Date: _____

Level 2 Assessment Adequate Yes No Corrective Actions Completed: Yes No

NJDEP Supervisor: _____ Signature of Supervisor: _____ Date: _____

Level 2 Assessment Adequate Yes No Corrective Actions Completed: Yes No

Comments on inadequacies (if any):

Licensed Operator Violations to be referred (if applicable):
Include citations.

RTCR Sampling Plan Approved Deficient Under Review

Comments (additional):