NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Water Supply Protection

Water System Operation Report

For Use by Public Water Systems that Treat with Chlorine and/or Fluoride

Public Water System Name	Reporting Month/Year __ __ / 2 0 __ __ M M Y Y Y Y	Date Report Submitted __ __/__ __ / 2 0 __ __ M M D D Y Y Y Y	Source Water Type(s) ☐ Surface ☐ Ground ☐ GWUDI ☐ Purchase with subsequent chlorination ☐ Purchase w/out subsequent chlorination
Public Water Supply ID NY ___ ___ ___ ___ ___ ___ ___	County	Town, Village, or City	

Treatment Plant(s) Identification: #1 _____; #2 _____; #3 _____

Fluoride Compound Used: ☐ Sodium fluoride (NaF - crystalline) ☐ Sodium fluorosilicate (Na_2SiF_6 - dry powder) ☐ Fluorosilicic acid (H_2SiF_6 - liquid)

Fluoride Residual Testing Method Used:_____

Fluoride Injection Point Location(s) Identification: #1_____; #2_____; #3_____

Date of Fluoride Split Sample _____

DATE	Source(s) in use	Treated water volume (1,000 gallons/day)	Chlorination				Fluoridation			Other Treatments / Readings			
			Gaseous		Liquid	Free chlorine residual at entry point (mg/l)	Scale/Meter Reading	Fluoride compound used per day (__lbs./__gals./__qts.)	Fluoride finished water concentration (mg/l)				
			Cylinder weight (lbs.)	Chlorine used per day (lbs.)	Hypochlorite added to crock (gallons or quarts)								
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2													
3													
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30													
31													
TOTAL													
AVG.													

Chlorine Mix Ratio = _____ quarts/gallons of _____% chlorine added to _____ gallons of water in crock.

Reported by:_____ Title:_____ NYS DOH Operator Certification Number:_____

Signature: _____ Date:_____ Operator Grade Level:_____

Microbiological Samples and Free Chlorine Residual

Sample Location	Date of Sample	Sample Type 1.Routine 2. Repeat	Total Coliform Positive	E.coli Positive	Free Chlorine Residual (mg/l)
			YES NO	YES NO	
			YES NO	YES NO	
			YES NO	YES NO	
			YES NO	YES NO	
			YES NO	YES NO	
			YES NO	YES NO	
			YES NO	YES NO	
			YES NO	YES NO	
			YES NO	YES NO	
			YES NO	YES NO	
			YES NO	YES NO	
			YES NO	YES NO	
			YES NO	YES NO	
			YES NO	YES NO	
			YES NO	YES NO	
			YES NO	YES NO	
			YES NO	YES NO	

Population Served:_____

Number of microbiological monitoring samples required:_____

Number of microbiological monitoring samples taken: _____

Did an M&R violation occur? Yes☐ No☐

If "Yes," check reason (s) below:

___Actual number of samples is fewer than required

___Did not collect/analyze repeat sample

___Did not collect/analyze for E. coli for positive total coliform from routine / repeat sample

Did an MCL violation occur? Yes☐ No☐

If "Yes," check reason(s) below (see also Part 5, Table 6 for additional information).

___For systems collecting less than 40 samples per month: two or more of the samples (routine and/or repeat) are positive for total coliform (= total coliform MCL violation).

___For systems collecting 40 or more samples per month: more than 5% of the samples (routine and/or repeat) are positive for total coliform (= total coliform MCL violation).

___The original sample was E.coli positive and at least 1 repeat sample was positive for total coliform (= E.coli MCL violation).

Reminder: System must collect a minimum of five (5) routine microbiological monitoring samples during the month following a repeat sample collection.

As required by 5-1.72, "Operation of a Public Water System," a copy of this form shall be sent to your local health department by the 10th calendar day of the next reporting period.

Sample Collector:_____ Date:_____

Sample Collector:_____ Date:_____

Name of NYSDOH Certified Laboratory:_____

Did any MCL violation occur? If so, please describe: _____

_____

_____

_____

Did an emergency or low pressure problem occur? Did source water bypass an existing treatment process in the system? If so, please explain: _____

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Comments:_____

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