Delaware General Health District
Dedicated to Your Health

Division of Environmental Health

1 West Winter Street, 2nd Floor, P.O. Box 570, Delaware, Ohio 43015 Phone: (740) 368-1700 Fax: (740) 368-1736

WATER SAMPLE REQUEST FORM

The Delaware General Health District performs testing of drinking water for homeowners and private water supplies through laboratory analysis. Standard testing for a new private water system (PWS) includes a field analysis of Nitrites/Nitrates, presence of Chlorine, total coliform, and Escherichia coli (E.coli) when necessary.

If you wish to have your water tested, print and fill out this form and send to the **Delaware General Health District, 1 West Winter St., P.O. Box 570, Delaware, Ohio 43015**.

After receiving the completed form and payment, a Sanitarian will contact you to arrange a time for sampling. Samples can only be collected on Wednesday afternoons.

Please fill out the following application so that we may better serve you in this process.

[ ] Existing PWS; Standard testing $74.10
[ ] Existing PWS; Special Sampling (*Please speak with a Sanitarian for pricing and availability*)

Please make checks payable to: **Delaware General Health District**. For any additional sampling other than standard testing as outlined in the paragraph above, please call 740-368-1700 for pricing.

Type of PWS   [ ] Well   [ ] Spring   [ ] Cistern   [ ] Pond

Property Owner Name:_____

Property Address:_____

City:_____State:_____Zip:_____Township:_____

Phone:_____Email:_____

Requestor Name:_____

Requestor Address:_____

City:_____State:_____Zip:_____Township:_____

Phone:_____Email:_____

I agree that I have read the above and submit my fee accordingly.

Signature:_____Date:_____

*Should your sample test positive for coliform bacteria, additional information will be provided to you for disinfecting your well. Please contact the Delaware General Health District at (740) 368-1700 for any questions or additional sampling requests.

--**OFFICE USE ONLY**--
Sanitarian: _____**Date Scheduled:** _____**AR #:**_____
Sanitarian Fee Breakdown:_____

Receipt #: _____**Receipt Date:** _____**Receipted by:**_____
EH HDIS Entry by: _____**Date:** _____   **HDIS:** <u>PRI</u>-Existing   or   <u>SPL</u>-Special

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