WATER TESTING DATA FORM

Sioux Falls Public Health Laboratory

City of Sioux Falls Health Department
521 North Main Avenue, Sioux Falls, SD 57104-5497 · 605-367-8777 Option 2
www.siouxfalls.gov/publichealthlab

BACTERIA TESTS REQUESTED

☐ Coliform P/A ☐ Total Coliform/Ecoli Count* ☐ HPC*
☐ Pool/Spa P/A ☐ Pool/Spa Repeat ☐ Other

Results available via portal in 24–48 hours.

COMPLETE BILLING NAME AND ADDRESS

Name: _____

Street: _____

City: _____ Zip Code: _____

Phone: _____

Above is new: ☐ Name ☐ Address ☐ Phone

WATER SUPPLIES ONLY

Name, Residence, Water System (if different from above):

_____

EPA/DENR System ID#: _____

Address: _____

Sample Collector: _____

Date Collected: _____ Time: _____

Type of Supply: ☐ Public ☐ Private ☐ Other (explain below)

Source: ☐ Lake ☐ Cistern ☐ Spring ☐ Other

Location of Sampling Tap: _____

Sample Site #: _____

Purpose of Sample (specify):

☐ Routine ☐ Repeat of Unsafe Sample ☐ Other (explain below)

CHECK ONE

☐ SWIMMING POOL ☐ SPA ☐ BEACH

Pool/Beach ID# _____

Name-Pool: _____

Sample Collector: _____

Date: _____

Pt. of Collection: _____

Time of Collection: _____

Chlorine Residual: _____

PH: _____

REMARKS: _____

_____

_____

_____

For Lab Use	Do not write in this space.	
DATE RECEIVED:	TIME:	LAB NO.:

Coliform: + – Pseudo: + – Ecoli: + –

HPC: _____ / mL

Total Coliform Count: _____ / 100 mL

Ecoli Count: _____ / 100 mL

*One dilution; additional fee for each additional dilution.