Daily Well Check

MONTH

WATER SYSTEM _____ PWS ID _____

OPERATOR(S) _____ TEST METHOD _____

DATE	TIME	FREE CHLORINE mg/L	SOURCE METER gal	WATER PRESSURE PSI	PUMP HOURS hours	INITIALS	NOTES
RANGE		_____ to _____	_____ to _____	_____ to _____	_____ to _____		
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							

Corrections: draw one line through the error, write the correct value beside it, then initial and date. Never erase or use correction fluid.

REVIEWED BY _____ DATE _____