District Health Department No. 4

PFAS Sampling Request

Complete the information below to request PFAS testing for your drinking water well.

Resident Information:

First Name: ______________________   Last Name: ________________________
Phone: _______________________    Email: _______________________________
First Name: ______________________   Last Name: ________________________
Phone: _______________________    Email: _______________________________

Property Information:

Street Address: ____________________________________
City: _____________________  State: ______  Zip: ___________
Rental property?  ☐ Yes  ☐ No  Business property?  ☐ Yes  ☐ No
Is the property address also the preferred mailing address? If no:
Mailing Address: ____________________________________
City: _____________________  State: ______  Zip: ___________
If renting, provide contact information for the owner:
Owner First Name: _______________ Owner Last Name: _______________
Address: ____________________________________
City: _____________________  State: ______  Zip: ___________
Phone: ______________________________    Email: _______________________________
Preferred time to be contacted to schedule sample collection:
  ☐ Morning  ☐ Afternoon  ☐ Evening

Well Information:

Depth of well (if known): _____________    Age of well (if known): _____________

For Health Department use:
Processed by: ___________________
Date Received: _______________
Date Submitted to DEQ: _______________

v 6.26.2018