

Stormwater Quarterly Visual Assessment Form
(Complete a separate form for each outfall you assess)

Name of Facility: _____

Outfall Name/Description: _____

Name of person collecting sample: _____

Title of person collecting sample: _____

Date & Time Discharge Began: _____

Date & Time Sample Collected: _____

Type of Precipitation: ___ Rainfall ___ Snowmelt

Observations

Color: ___ No ___ Yes

If yes, please describe: _____

Odor: ___ No ___

If yes, please describe: _____

Clarity: ___ Clear ___ Slightly Cloudy ___ Cloudy ___ Opaque

Are any of the following present?

Floating Solids ___ No ___ Yes

Settled Solids* ___ No ___ Yes

Suspended Solids ___ No ___ Yes

Foam (gently shake sample) ___ No ___ Yes

Oil Sheen ___ No ___ Yes

Are there any other indicators of Stormwater Pollution? ___ No ___ Yes

If yes, please describe _____

Description of measures taken to determine the source of any contaminants and changes to best management practices to prevent contact with stormwater: _____

* Observe for settled solids after allowing the sample to sit for approximately 5 minutes.