

**State of Oregon Drinking Water Program
Monthly Disinfection Report for Ground Water Systems**

System Name Scrauel Hill WATER PWS ID# 4100018
 Month/Year 12 / 21 Entry Point: Scrauel Hill Pump Required Minimum Residual .3 mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	8:30am		.39	
2			.39	
3			.38	
4			.38	
5			.37	
6			.37	
7			.38	
8			.38	
9			.39	
10			.39	
11			.37	
12			.37	
13			.37	
14			.36	
15			.36	
16			.39	
17			.38	
18			.39	
19			.39	
20			.40	
21			.40	
22			.40	
23			.39	
24			.39	
25			.39	
26			.39	
27			.38	
28			.38	
29			.37	
30			.37	
31			.37	

Was the chlorine residual ever less than the required minimum residual of .3 mg/L? Yes No
 If yes, what was the longest time period until the required level was restored? _____ hours - If > 4 hours, Drinking Water Program to be notified by end of next business day.

<p>GWS Serving 3,300 or Fewer</p> <p>If yes, did you monitor every four hours until the residual returned to _____ mg/L as required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Attach those results and submit them with this form.</p>	<p>GWS Serving More Than 3,300</p> <p>Did continuous monitoring equipment fail at any time this reporting month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, were grab samples collected every four hours until the continuous monitoring equipment was returned to service as required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Attach grab sample results and submit them with this form.</p>	<p>Date continuous monitoring equipment failed: / /</p> <p>Date it was returned to service: / /</p>
--	--	---

Printed Name: Montie TORGESSON Title: MANAGER Operator Certification #: _____
 Signature: [Signature] Phone #: (541) 760-1791 OR
 Date: 12 / 22 Small Groundwater System