

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

System Name Scrauel Hill WATER PWS ID# 4100018
 Month/Year 12 123 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	8:00 AM		.38	
2			.38	
3			.38	
4			.39	
5			.38	
6			.39	
7			.38	
8			.37	
9			.37	
10			.38	
11			.38	
12			.39	
13			.40	
14			.40	
15			.41	
16			.41	
17			.40	
18			.40	
19			.41	
20			.41	
21			.42	
22			.41	
23			.41	
24			.41	
25			.39	
26			.39	
27			.40	
28			.39	
29			.38	
30			.38	
31			.39	

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>
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Printed Name: Montre TORGESSON Title: MANAGER Operator Certification #: _____
 Signature: [Signature] Phone #: (541) 760-1791 OR
 Date: 12 21 24 Small Groundwater System