

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

System Name Scrauel Hill WATER PWS ID# 4100018
 Month/Year MAR 1 2024 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			.41	
2			.41	
3			.40	
4			.42	
5			.41	
6			.39	
7			.39	
8			.39	
9			.40	
10			.40	
11			.39	
12			.38	
13			.39	
14			.38	
15			.40	
16			.40	
17			.41	
18			.41	
19			.41	
20			.42	
21			.41	
22			.41	
23			.41	
24			.39	
25			.39	
26			.39	
27			.37	
28			.37	
29			.37	
30			.36	
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 align="center">GWS Serving More Than 3,300</p> <table border="0"> <tr> <td style="width: 60%;"> Did continuous monitoring equipment fail at any time this reporting month? <input type="checkbox"/> Yes <input type="checkbox"/> No 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 Attach grab sample results and submit them with this form. </td> <td style="width: 40%;"> Date continuous monitoring equipment failed: / / Date it was returned to service: / / </td> </tr> </table>	Did continuous monitoring equipment fail at any time this reporting month? <input type="checkbox"/> Yes <input type="checkbox"/> No 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 Attach grab sample results and submit them with this form.	Date continuous monitoring equipment failed: / / Date it was returned to service: / /
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Printed Name: Montie TORGESSON Title: MANAGER Operator Certification #: _____
 Signature: [Signature] Phone #: (541) 760-1791 OR
 Date: 4 / 1 / 24 Small Groundwater System