

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

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

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: Monte Torresson Title: MANAGER Operator Certification #: _____
 Signature: [Signature] Phone #: (541) 760-1791 OR
 Date: 12/25/24 Small Groundwater System