

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

System Name Scareel Hill WATER			PWS ID# 4100018	
Month/Year 3 125		Entry Point: Sunset, 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		.39	
2			.39	
3			.38	
4			.39	
5			.39	
6			.38	
7			.38	
8			.38	
9			.40	
10			.40	
11			.41	
12			.41	
13			.39	
14			.39	
15			.39	
16			.39	
17			.39	
18			.39	
19			.40	
20			.40	
21			.40	
22			.41	
23			.39	
24			.39	
25			.40	
26			.40	
27			.39	
28			.39	
29			.40	
30			.41	
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>
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Printed Name: Monty TORRESON Signature: <i>[Signature]</i> Date: 4/1/25	Title: MANAGER Phone #: (541) 760-1791	Operator Certification #: _____ OR Small Groundwater System <input checked="" type="checkbox"/>
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