

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

System Name Bear Creek MHP PWS ID# 41 00050
 Month/Year 9 124 Entry Point: Spire 51 Required Minimum Residual .4 mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	11:50 a	Wells 1-2-3 Combined	.55	
2	9:53 a		.55	
3	9:23 a		.5	
4	9:15 a		.5	
5	9:01 a		.5	
6	10:03 a		.5	
7	10:47 a		.5	
8	11:40 a		.55	
9	10:02 a		.55	
10	9:10 a		.55	
11	10:21 a		.55	
12	10:08 a		.55	
13	10:02 a		.5	
14	9:22 a		.5	
15	10:27 a		.5	
16	9:14 a		.5	
17	11:06 a		.5	
18	10:26 a		.5	
19	9:44 a		.5	
20	10:12 a		.55	
21	10:41 a		.55	
22	11:10 a		.55	
23	8:53 a		.5	
24	11:18 a		.5	
25	10 a		.5	
26	9:24 a		.5	
27	9:04 a		.5	
28	10:26 a		.5	
29	11:14 a		.5	
30	9:39 a		.5	
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Was the chlorine residual ever less than the required minimum residual of .4 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.

GWS Serving 3,300 or Fewer	GWS Serving More Than 3,300	
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 Attach those results and submit them with this form.	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: _____ / _____ / _____

Printed Name: Mike Skinner Title: Water System Operator Operator Certification #: _____
 Signature: [Signature] Phone #: (541) 914-8434 OR
 Date: 10 11 2004 Small Groundwater System