

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

System Name: **Canby Regency** PWS ID# **4 1 00163**
 Treatment Room
 Month/Year: **February / 2024** Minimum Residual: **0.3 Mg/L** 

	Time	Source(s) in use	Free chlorine Residual (mg/L)	pH	Notes
1	07:52-	Spring	0.8	7.97	
2	13:36	Spring	0.8	7.96	
3	10:21	Spring	0.8	7.92	
4	15:25	Spring	0.8	7.94	
5	14:14	Spring	0.8	7.91	
6	10:01	Spring	0.8	7.91	
7	07:19	Spring	0.8	7.94.	
8	07:33	Spring	0.8	7.92	
9	12:43	Spring	0.8	7.91	
10	12:43	Spring	0.8	8.01	
11	14:46	Spring	0.8	7.98	
12	09L10	Spring	0.8	8.0	
13	17:40	Spring	0.8	7.96	
14	09:07	Spring	0.8	8.04	
15	10:04	Spring	0.8	7.99	
16	09:08	Spring	0.8	7.99	
17	10:41	Spring	1.0	8.02	
18	09:12	Spring	1.0	8.01	
19	08:54	Spring	1.0	7.91	
20	09:22	Spring	0.8	7.99	
21	08:33	Spring	0.8	7.89	
22	09:39	Spring	0.8	7.95	
23	12:00	Spring	0.8	8.0	
24	10:14	Spring	0.8	8.05	
25	14:32	Spring	0.8	8.08	
26	11:45	Spring	0.8	8.04	
27	10:13	Spring	0.8	8.02	
28	07:14	Spring	0,3	8.05	
29	07:36	Spring	0.6	8.01	
30	--	Spring	--	--	
31	--	Spring	--	--	

Were the chloring residuals at the treatment room ever less than the required minimum residual of .3mg/L? Yes No
 If yes, what was the 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

If yes, did you monitor chlorine residuals at treatment room every four hours until the residual returned to .3mg/L as required?
 Yes No

Attach those results and submit them with this form.

Printed Name: _____ Title: **DRC**
 Signature: *Mary L. Howell* (Phone #: () _____)
 Date: **07/09/2024** **503-255-1619**

Operator Certification # _____
 OR **D-142**
 Small Ground Water System