

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

System Name **Regency of Oregon, Inc./Canby Regency MHP**

PWS ID# **4 1 4 1 00163**



Month/Year **12/2025**

Entry Point: **Treatment Room**

Required Minimum Residual **0.3 mg/L**

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	15:03	Spring	0.6	
2	09:46	" "	0.6	
3	10:11	" "	0.6	
4	09:50	" "	0.6	
5	10:54	" "	0.6	
6	11:44	" "	0.6	
7	15:00	" "	0.6	
8	14:24	" "	0.6	
9	10:40	" "	0.6	
10	10:25	" "	0.6	
11	12:00	" "	0.8	
12	14:51	" "	0.8	
13	15:40	" "	0.8	
14	15:04	" "	0.6	
15	11:36	" "	0.6	
16	17:20	" "	0.6	
17	--	" "	n/a	No electricity
18	07:40	" "	0.6	
19	15:04	" "	0.6	
20	11:03	" "	0.6	
21	15:42	" "	0.6	
22	10:20	" "	0.6	
23	08:15	" "	0.6	
24	09:26	" "	0.6	
25	07:00	" "	0.6	
26	16:21	" "	0.6	
27	12:22	" "	0.6	
28	13:48	" "	0.6	
29	12:29	" "	0.6	
30	17:15	" "	0.6	
31	10:41	--	0.6	

Was the chlorine residual ever less than the required minimum residual of 0.3 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.

GWS Serving 3,300 or Fewer

If yes, did you monitor every four hours until the residual returned to _____ mg/L as required? Yes No

Attach those results and submit them with this form.

Printed Name: **Phillip Merrill**

Title: **DRC**

Operator Certification #: **T008670**

Signature: *Phillip Merrill*

Phone #: **(503)734.7400**

OR

Date: **1-8-2025 /**

Small Groundwater System

Return by 10th of following month by either email dwp.dmce@odhsoha.oregon.gov; fax 971-673-0458; or mail to Drinking Water Services, PO Box 14350, Portland, OR 97293-0350.