

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

System Name **Riverstone MHP**

PWS ID# **4 1 00240**

Month/Year **\_ 2/2021**

Entry Point: **Pump House**

Required Minimum Residual **.20 mg/L**

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	9:30	Well 1 and 2	.21	
2	9:30	"	.27	
3	9:30	"	.26	
4	9:30	"	.28	
5	9:30	"	.27	
6	"	"	.24	
7	"	"	.33	
8	"	"	.30	
9	"	"	.29	
10	11	"	.25	
11	11	"	.29	
12	"	"	.27	
13	"	"	.28	
14	"	"	.24	
15	"	"	.28	
16	"	"	.29	
17	"	"	.27	
18	"	"	.30	
19	"	"	.29	
20	"	"	.22	
21	"	"	.30	
22	"	"	.27	
23	"	"	.28	
24	"	"	.27	
25	"	"	.28	
26	"	"	.29	
27	"	"	.24	
28	"	"	.28	
29		"		
30		"		
31		"		

Was the chlorine residual ever less than the required minimum residual of .20 mg/L? ☐ Yes ☒ No

If yes, what was the longest time period until the required level was restored?  
notified by end of next business day.

hours - If > 4 hours, Drinking Water Program to be

**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.

**GWS Serving More Than 3,300**

Did continuous monitoring equipment fail at any time this reporting month? ☐ Yes ☐ No

If yes, were grab samples collected every four hours until the continuous monitoring equipment was returned to service as required? ☐ Yes ☐ No

Attach grab sample results and submit them with this form.

Date continuous monitoring equipment failed:

/ /

Date it was returned to service:

/ /

Printed Name: **Lee Wege**

Title: **Manager/Operator**

Operator Certification #:

Signature: 

Phone #: **(541) 942-4147**

OR

Date: **3/1/21**

Small Groundwater System ☒