

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

System Name **Riverstone MHP**

PWS ID# **41 00240**

Month/Year **6/2023**

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	.34	
2	9:30	"	.32	
3	9:30	"	.33	
4	9:30	"	.34	
5	9:30	"	.34	
6	9:30	"	.34	
7	9:30	"	.32	
8	9:30	"	.33	
9	9:30	"	.33	
10	9:30	"	.34	
11	9:30	"	.34	
12	9:30	"	.35	
13	9:30	"	.33	
14	9:30	"	.35	
15	9:30	"	.30	
16	9:30	"	.32	
17	9:30	"	.33	
18	9:30	"	.34	
19	9:30	"	.33	
20	9:30	"	.33	
21	9:30	"	.32	
22	9:30	"	.32	
23	9:30	"	.33	
24	9:30	"	.31	
25	9:30	"	.30	
26	9:30	"	.31	
27	9:30	"	.31	
28	9:30	"	.37	
29	9:30	"	.29	
30	9:30	"	.29	
31	9:30	"		

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? \_\_\_\_\_ 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.

**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: **James T Boardman**

Title: **Manager/Operator**

Signature: \_\_\_\_\_

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

Date: **6/1/23**

Operator Certification #:

OR

Small Groundwater System ☒