

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

System Name **Riverstone MHP**

PWS ID# **4 1 00240**

Month/Year **_03/2026**

Entry Point: **Pump House**

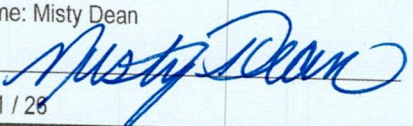
Required Minimum Residual **.20 mg/L**

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	.32	
2	9:30	"	.31	
3	9:30	"	.33	
4	9:30	"	.34	
5	9:30	"	.37	
6	9:30	"	.38	
7	9:30	"	.38	
8	9:30	"	.39	
9	9:30	"	.41	
10	9:30	"	.40	
11	9:30	"	.36	
12	9:30	"	.34	
13	9:30	"	.33	
14	9:30	"	.35	
15	9:30	"	.34	
16	9:30	"	.33	
17	9:30	"	.31	
18	9:30	"	.35	
19	9:30	"	.34	
20	9:30	"	.33	
21	9:30	"	.32	
22	9:30	"	.31	
23	9:30	"	.30	
24	9:30	"	.31	
25	9:30	"	.32	
26	9:30	"	.29	
27	9:30	"	.27	
28	9:30	"	.29	
29	9:30	"	.31	
30	9:30	"	.34	
31	9:30	"	.38	

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
 Date continuous monitoring equipment failed: _____ / _____ / _____
 If yes, were grab samples collected every four hours until the continuous monitoring equipment was returned to service as required? Yes No
 Date it was returned to service: _____ / _____ / _____
 Attach grab sample results and submit them with this form.

Printed Name: **Misty Dean**
 Signature: 
 Date: **03 / 1 / 26**

Title: **Manager/Operator**
 Phone #: **(541) 942-4147**

Operator Certification #: _____
 OR
 Small Groundwater System