

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

System Name **Neahkahnie Water District**

PWS ID# **4 1 00506**

Month/Year **09 / 2021** Entry Point: **WTP-B (Hyd.#66)**

Required Minimum Residual **0.4 mg/L**

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1		Springs 1-3 + Pirates spr.	0.60	
2			0.56	
3			0.56	
4			0.51	
5			0.62	
6			0.56	
7			0.63	
8			0.56	
9			0.61	
10			0.61	
11			0.57	
12			0.54	
13			0.58	
14			0.58	
15			0.58	
16			0.62	
17			0.55	
18			0.46	
19			0.47	
20			0.51	
21			0.49	
22			0.48	
23			0.52 0.44	
24			0.52	
25			0.57	
26			0.48	
27			0.46	
28			0.51	
29			0.45	
30			0.43	
31				

Was the chlorine residual ever less than the required minimum residual of **0.40** 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.

<p>GWS Serving 3,300 or Fewer</p> <p>If yes, did you monitor every four hours until the residual returned to _____ mg/L as required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Attach those results and submit them with this form.</p>	<p>GWS Serving More Than 3,300</p> <p>Did continuous monitoring equipment fail at any time this reporting month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, were grab samples collected every four hours until the continuous monitoring equipment was returned to service as required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Attach grab sample results and submit them with this form.</p>	<p>Date continuous monitoring equipment failed: _____ / _____ / _____</p> <p>Date it was returned to service: _____ / _____ / _____</p>
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Printed Name: **Scott A Morrill** Title: **System Op/DRC** Operator Certification #: **F-9278**
 Signature: *Scott A Morrill* Phone #: **(503) 804.4649** OR **D-9279**
 Date: **09/30/2021** Small Groundwater System