

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

System Name City of Maupin Water Ave PWS ID# 41 00510
 Month/Year June/2025 Entry Point Lower Res. Required Minimum Residual 0.30 mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	7:43	SB 1-2-3	0.66	
2	6:55		0.67	Running
3	7:04		0.57	
4	6:54		0.69	Running
5	6:53		0.61	
6	6:28		0.69	Running
7	7:55		0.61	
8	9:15		0.68	Running
9	8:01		0.67	Running
10	7:26		0.70	Running
11	7:00		0.61	
12	6:57		0.69	Running
13	6:21		0.70	Running
14	6:40		0.64	
15	7:45		0.72	Running
16	6:31		0.64	
17	6:41		0.75	Running
18	6:31		0.72	Running
19	6:40		0.70	Running
20	9:05		0.64	
21	9:13		0.58	
22	9:20		0.61	
23	7:07		0.65	Running
24	6:57		0.72	Running
25	7:04		0.64	
26	7:01		0.70	Running
27	6:53		0.64	
28	6:40		0.63	
29	6:23		0.65	
30	6:52		0.63	

Was the chlorine residual ever less than the required minimum residual of _____ 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: Kirk Shields
 Signature: [Signature]
 Date: 1 / 1

Title: Foreman
 Phone #: (541) 395 2698

Operator Certification #: 89131
 OR
 Small Groundwater System ☐

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

System Name City of Maupin

Springs Pump House

PWS ID# 41 00510

Month/Year *June/2005* Entry Point

Required Minimum Residual *0.30* mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	8:00	<i>SB 1-2-3</i>	<i>0.56</i>	<i>Running</i>
2	7:10		<i>0.50</i>	<i>Running</i>
3	7:16		<i>0.53</i>	<i>Running</i>
4	7:13		<i>0.51</i>	<i>Running</i>
5	7:06		<i>0.52</i>	<i>Running</i>
6	6:41		<i>0.67</i>	
7	8:41		<i>0.58</i>	
8	8:56		<i>0.53</i>	
9	8:16		<i>0.69</i>	
10	7:41		<i>0.68</i>	
11	7:18		<i>0.68</i>	
12	7:14		<i>0.50</i>	<i>Running</i>
13	6:30		<i>0.48</i>	<i>Running</i>
14	6:52		<i>0.73</i>	
15	7:58		<i>0.71</i>	
16	6:45		<i>0.53</i>	<i>Running</i>
17	6:57		<i>0.51</i>	<i>Running</i>
18	6:45		<i>0.52</i>	<i>Running</i>
19	6:55		<i>0.81</i>	<i>Running</i>
20	8:55		<i>0.54</i>	<i>✓</i>
21	8:59		<i>0.56</i>	
22	7:10		<i>0.62</i>	
23	7:22		<i>0.52</i>	<i>Running</i>
24	7:03		<i>0.54</i>	<i>Running</i>
25	7:17		<i>0.54</i>	<i>Running</i>
26	7:15		<i>0.49</i>	<i>Running</i>
27	7:17		<i>0.46</i>	<i>Running</i>
28	6:54		<i>0.71</i>	
29	6:35		<i>0.72</i>	
30	7:06		<i>0.69</i>	

Was the chlorine residual ever less than the required minimum residual of _____ 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:

Kirk Shields

Title:

Foreman

Operator Certification #:

OR

89131

Signature:

[Signature]

Phone #:

541) 395 2698

Small Groundwater System ☐

Date:

1 1

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

System Name City of Maupin

East Maupin

PWS ID# 41 00510

Month/Year *June/2005* Entry Point:

Required Minimum Residual *0.30* mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	8:20	<i>SB 1-2-3</i>	<i>0.92</i>	
2	7:20		<i>0.75</i>	
3	7:39		<i>0.37</i>	
4	7:35		<i>0.94</i>	
5	7:19		<i>0.73</i>	
6	7:15		<i>0.49</i>	
7	8:15		<i>0.54</i>	
8	8:40		<i>0.45</i>	
9	8:25		<i>0.67</i>	
10	7:24		<i>0.54</i>	
11	7:30		<i>0.56</i>	
12	7:35		<i>0.42</i>	
13	6:40		<i>0.51</i>	
14	6:45		<i>0.56</i>	
15	8:28		<i>0.75</i>	
16	7:00		<i>0.82</i>	
17	7:12		<i>0.47</i>	
18	6:55		<i>0.52</i>	
19	7:05		<i>0.68</i>	
20	8:30		<i>0.53</i>	
21	8:45		<i>0.41</i>	
22	9:30		<i>0.46</i>	
23	7:35		<i>0.49</i>	
24	7:20		<i>0.41</i>	
25	7:25		<i>0.40</i>	
26	7:35		<i>0.52</i>	
27	7:33		<i>0.34</i>	
28	7:15		<i>0.50</i>	
29	6:34		<i>0.61</i>	
30	7:50		<i>0.40</i>	
31				

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

mg/L? ☐ Yes ☐ No

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: *Kirk Shields*

Title: *Foreman*

Operator Certification #: _____

Signature: *Kirk Shields*

Phone #: *(541)*

OR

Date: *1 1*

395 2688

Small Groundwater System ☐