

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

System Name Pioneer Park CO-OP PWS ID# 41 00784  
 Month/Year 3/21 Entry Point: \_\_\_\_\_ Required Minimum Residual .2 mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1			.40	
2			.35	
3			.35	
4			.35	
5			.40	
6			.45	
7			.50	
8			.45	
9			.45	
10			.40	
11			.40	
12			.40	
13			.40	
14			.40	
15			.40	
16			.40	
17			.40	
18			.40	
19			.40	
20			.40	
21			.40	
22			.40	
23			.30	
24			.30	
25			.30	
26			.30	
27			.40	
28			.30	
29			.30	
30			.30	
31			.40	

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 residual level was restored? \_\_\_\_\_ Hours - If > 4 hours, Drinking Water Program to be notified by end of next business day.

<p><b>GWS Serving 3,300 or Fewer</b></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><i>Attach those results and submit them with this form.</i></p>	<p><b>GWS Serving More Than 3,300</b></p> <p>Did continuous monitoring equipment fail at any time this reporting month? <input checked="" 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><i>Attach grab sample results and submit them with this form.</i></p>	<p>Date continuous monitoring equipment failed: _____/_____/____</p> <p>Date it was returned to service: _____/_____/____</p>
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Printed Name: MIKE BEYER Title: \_\_\_\_\_ Operator Certification #: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ OR  
 Date: 3/31/21 Small Groundwater System

