

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

System Name PIONEER PARK COOP PWS ID# 41 00784
 Month/Year 11/2021 Entry Point: _____ 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			.20	
2			.20	
3			.20	
4			.20	
5			.20	
6			.20	
7			.20	
8			.20	
9			.20	
10			.20	
11			.20	
12			.20	
13			.20	
14			.20	
15			.20	
16			.20	
17			.20	
18			.20	
19			.20	
20			.20	
21			.20	
22			.20	
23			.20	
24			.20	
25			.20	
26			.20	
27			.20	
28			.20	
29			.20	
30			.20	
31			X	

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.

<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: MIKE BEYER Title: _____ Operator Certification #: _____
 Signature: _____ Phone #: (____) _____
 Date: 12/2/21

OR
Small Groundwater System