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

System Name __PIONEER PARK CO-OP__   PWS ID# 41 __OO784__

Month/Year __1 / 2023__ 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			.30	
2			.30	
3			.30	
4			.30	
5			.30	
6			.30	
7			.30	
8			.30	
9			.30	
10			.30	
11			.30	
12			.30	
13			.30	
14			.70	
15			.30	
16			.70	
17			.30	
18			.30	
19			.30	
20			.30	
21			.30	
22			.30	
23			.30	
24			.30	
25			.30	
26			.30	
27			.30	
28			.30	
29			.30	
30			.30	
31			.50 .3D	

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 re___ ed 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	GWS Serving More Than 3,300	
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.*	Did continuous mo___ ring equipment fail at any time this reporting month? ☐r___ ☐ No If yes, were grab samples ___cted every four hours until the continuous monitoring equip___ ✝was returned to service as required? ☐ Yes ☐ ___ *Attach grab sample results and submit them with this form.*	Date continuous monitoring equipment failed: ___/___/___ Date it was returned to service: ___/___/___

Printed Name: __MIKE BEYER__   Title: _____
Signature: _____   Phone #: (___) _____
Date: __1 / 31 / 2023__

Operator Certification #: _____
OR
Small Groundwater System ☐

December 19, 2012