

**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 7/2023 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			.20	
2			.20	
3			.20	
4			.20	
5			.20	
6			.20	
7			.20	
8			.20	
9			.30	
10			.30	
11			.20	
12			.20	
13			.20	
14			.30	
15			.30	
16			.30	
17			.30	
18			.25	
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			.30	

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>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 checked="" 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 checked="" type="checkbox"/> No</p> <p>Attach grab sample results and submit them with this form.</p>
<p>Date continuous monitoring equipment failed: _____/_____/_____ Date it was returned to service: _____/_____/_____</p>	

Printed Name: MIKE BEYER Title: _____ Operator Certification #: _____
 Signature: _____ Phone #: (____) _____ OR
 Date: 7/31/23 Small Groundwater System