

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

System Name PIDNEER PARK CO-OP PWS ID# 41 00784
 Month/Year 6/2024 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			.50	
3			.50	
4			.50	
5			.50	
6			.50	
7			.50	
8			.50	
9			.50	
10			.50	
11			.50	
12			.40	
13			.40	
14			.30	
15			.40	
16			.40	
17			.40	
18			.40	
19			.40	
20			.40	
21			.30	
22			.30	
23			.30	
24			.30	
25			.35	
26			.35	
27			.30	
28			.30	
29			.30	
30			.30	
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 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><i>Attach those results and submit them with this form.</i></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"/> 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 checked="" 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: _____/_____/_____ Date it was returned to service: _____/_____/_____</p>
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Printed Name: MIKE BEYER Title: _____ Operator Certification #: _____
 Signature: _____ Phone #: (____) _____ OR
 Date: 7/1/24 Small Groundwater System