

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 12/2024 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			.30	
2			.30	
3			.30	
4			.30	
5			.30	
6			.30	
7			.30	
8			.30	
9			.30	
10			.30	
11			.30	
12			.30	
13			.40	
14			.40	
15			.40	
16			.40	
17			.35	
18			.35	
19			.35	
20			.35	
21			.35	
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 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><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 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 REYER Title: _____ Operator Certification #: _____
 Signature: _____ Phone #: (____) _____ OR
 Date: 1/3/25 Small Groundwater System