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

System Name __PIONEER PARK CO-OP__   PWS ID# 4 1 __00784__

Month/Year __/20__   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			.30	
15			.30	
16			.30	
17			.25	
18			.25	
19			.25	
20			.25	
21			.25	
22			.30	
23			.25	
24			.25	
25			.25	
26			.25	
27			.25	
28			.25	
29			.25	
30			.25	
31			.25	
			.25	

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 m~~onitoring~~ equipment fail at any time this reporting month? ☐ Y~~es~~ ☐ No If yes, were grab samples ~~collected every four hours until the~~ continuous monitoring equip~~ment~~ was returned to service as required? ☑ Yes ☐ N~~o~~ *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: __4 / 1 / 25__

Operator Certification #: _____

OR

Small Groundwater System ☐

December 19, 2012