

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

System Name: **McHenry Palisades**

PWS ID: **41 00923**

**FEBRUARY**

**2023 /**

Month/Year

Entry Point: **PUMPHOUSE**

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	0700	WELL EP	48	
2	0713	WELL EP	49	
3	0912	WELL EP	48	
4	1000	WELL EP	48	
5	2330	WELL EP	50	
6	2210	WELL EP	49	
7	2305	WELL EP	48	
8	2200	WELL EP	48	
9	0900	WELL EP	48	
10	2015	WELL EP	49	
11	0900	WELL EP	47	
12	0723	WELL EP	48	
13	2000	WELL EP	48	
14	2100	WELL EP	47	
15	0715	WELL EP	48	
16	0718	WELL EP	48	
17	1600	WELL EP	53	
18	1315	WELL EP	52	
19	2105	WELL EP	49	
20	0727	WELL EP	48	
21	0816	WELL EP	48	
22	0711	WELL EP	47	
23	1830	WELL EP	53	
24	2100	WELL EP	52	
25	0745	WELL EP	49	
26	0832	WELL EP	51	
27	1832	WELL EP	47	
28	2100	WELL EP	49	
29				
30				
31				

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.

**GWS Serving 3,300 or Fewer**

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.

**GWS Serving More Than 3,300**

Did continuous monitoring equipment fail at any time this reporting month?  Yes  No

If yes, were grab samples collected every four hours until the continuous monitoring equipment was returned to service as required?  Yes  No

Attach grab sample results and submit them with this form.

Date continuous monitoring equipment failed: / /

Date it was returned to service: / /

Printed Name: **LONNY SAYLES**

Title: **DRC**

Operator Certification #: **6085**

Signature: 

Phone #: **(541-) 206-3976**

OR

Date: **03/07/2023**

Small Groundwater System