

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

System Name *Mcke Bridge M.H.P.*

PWS ID# *4101165*

Month/Year *04 / 2023* Entry Point:

Required Minimum Residual *.50* mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	10:00	#1 well	0.60	<b>RECEIVED</b>  MAY 03 2023  Certification Drinking Water Services
2	4:10	#1 well	0.60	
3	3:00	#1 well	0.60	
4	6:10	#1 well	0.60	
5	4:30	#1 well	0.60	
6	9:30	#1 well	0.50	
7	8:00	#1 well	0.60	
8	5:40	#1 well	0.50	
9	6:00	#1 well	0.50	
10	5:30	#1 well	0.50	
11	10:30	#1 well	0.60	Contact MARK 541-210-2984
12	10:00	#1 well	0.50	
13	2:00	#1 well	0.50	
14	3:00	#1 well	0.50	
15	6:00	#1 well	0.50	
16	6:15	#1 well	0.50	
17	5:40	#1 well	0.50	
18	6:00	#1 well	0.50	
19	7:00	#1 well	0.50	
20	3:10	#1 well	0.40	
21	2:30	#1 well	0.40	
22	1:00	#1 well	0.40	
23	5:30	#1 well	0.40	
24	4:00	#1 well	0.20	
25	6:05	#1 well	0.20	
26	6:00	#1 well	0.20	
27	12:10	#1 well	0.20	
28	1:30	#1 well	0.20	
29	2:10	#1 well	0.20	
30	8:00	#1 well	0.20	
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Was the chlorine residual ever less than the required minimum residual of *.50* 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><b>GWS Serving 3,300 or Fewer</b></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><b>GWS Serving More Than 3,300</b></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>Attach grab sample results and submit them with this form.</p>	<p>Date continuous monitoring equipment failed: _____ / _____ / _____</p> <p>Date it was returned to service: _____ / _____ / _____</p>
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Printed Name: <i>Steve Krupicka</i>	Title: <i>water tester</i>	Operator Certification #: _____
Signature: <i>Steve Krupicka</i>	Phone #: <i>(541) 210 2984</i>	<input checked="" type="checkbox"/> OR
Date: <i>0510212023</i>	<i>541 951 3901</i>	Small Groundwater System <input type="checkbox"/>

Return by 10<sup>th</sup> of following month by either email [dwp.dmce@state.or.us](mailto:dwp.dmce@state.or.us); fax 971-673-0694;

or mail to: Drinking Water Services, PO Box 14350, Portland, OR 97293-0350.

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