

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

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 Certification  
 Drinking Water Services

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

PWS ID# 4101165

Month/Year *12 / 2023* Entry Point:

Required Minimum Residual *0.50* mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	6:00	#1 well	0.4	
2	3:10	#1 well	0.5	
3	4:00	#1 well	0.5	
4	4:20	#1 well	0.5	
5	3:00	#1 well	0.5	
6	10:00	#1 well	0.5	
7	10:30	#1 well	0.5	
8	9:00	#1 well	0.5	
9	8:30	#1 well	0.5	
10	8:00	#1 well	0.5	
11	3:00	#1 well	0.6	
12	5:10	#1 well	0.5	
13	7:00	#1 well	0.4	
14	9:00	#1 well	0.5	Contact Mark 541-210-2984
15	3:30	#1 well	0.5	
16	5:00	#1 well	0.5	
17	4:00	#1 well	0.5	
18	5:00	#1 well	0.5	
19	7:30	#1 well	0.5	
20	5:00	#1 well	0.5	
21	11:00	#1 well	0.5	
22	8:00	#1 well	0.5	
23	9:10	#1 well	0.5	
24	5:00	#1 well	0.5	
25	5:30	#1 well	0.5	
26	4:00	#1 well	0.6	
27	10:00	#1 well	0.5	
28	8:30	#1 well	0.5	
29	4:30	#1 well	0.5	
30	7:10	#1 well	0.5	
31	5:00	#1 well	0.4	

Was the chlorine residual ever less than the required minimum residual of *0.50* 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 checked="" 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: *Steven Krupicka* Title: *Water Tester* Operator Certification #: \_\_\_\_\_  
 Signature: *Steven Krupicka* Phone #: *(541) 210 2984* OR \_\_\_\_\_  
 Date: *01/01/2024* *541 961 3901* Small Groundwater System

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

Received Time Jan. 7, 2024 1:55PM No. 0050  
 State of Oregon Drinking Water Services, PO Box 14350, Portland, OR 97203-0350.