

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

System Name Mckee Bridge m. H.P.

PWS ID# 4101165

Month/Year 01 / 2024 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	12:30	#1 well	0.5	
2	10:30	#1 well	0.5	
3	7:30	#1 well	0.5	
4	8:00	#1 well	0.5	
5	5:00	#1 well	0.5	
6	6:00	#1 well	0.4	
7	4:00	#1 well	0.5	
8	6:00	#1 well	0.4	
9	5:10	#1 well	0.4	
10	6:30	#1 well	0.5	
11	6:00	#1 well	0.5	
12	3:00	#1 well	0.5	
13	8:30	#1 well	0.6	
14	5:30	#1 well	0.5	
15	6:30	#1 well	0.5	Contact Mark
16	7:30	#1 well	0.5	541-210-2984
17	7:00	#1 well	0.5	
18	5:50	#1 well	0.5	
19	6:00	#1 well	0.5	
20	7:10	#1 well	0.5	
21	5:20	#1 well	0.5	
22	6:10	#1 well	0.4	
23	7:15	#1 well	0.5	
24	4:00	#1 well	0.5	
25	4:00	#1 well	0.5	
26	6:00	#1 well	0.5	
27	9:00	#1 well	0.5	
28	10:00	#1 well	0.4	
29	2:00	#1 well	0.4	
30	2:30	#1 well	0.2	
31	6:00	#1 well	0.0	

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 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: <u>Steven Krupicka</u>	Title: <u>water tester</u>	Operator Certification #: _____
Signature: <u>[Signature]</u>	Phone #: <u>(541) 210 2984</u>	OR
Date: <u>02/02/2024</u>	<u>541 951 8901</u>	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; cas, PO Box 14350, Portland, OR 97293-0350.

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