

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 *02 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	10:00	#1 well	0.0	
2	8:00	#1 well	0.0	
3	4:00	#1 well	0.4	
4	2:30	#1 well	0.5	
5	1:30	#1 well	0.5	
6	8:00	#1 well	0.4	
7	9:00	#1 well	0.4	
8	12:30	#1 well	0.4	
9	6:00	#1 well	0.5	
10	6:30	#1 well	0.5	
11	9:00	#1 well	0.5	
12	2:00	#1 well	0.5	
13	10:00	#1 well	0.5	CONTACT MARK
14	1:00	#1 well	0.5	541-210-2984
15	8:30	#1 well	0.5	
16	10:30	#1 well	0.5	
17	6:30	#1 well	0.5	
18	2:00	#1 well	0.5	
19	3:00	#1 well	0.5	
20	7:00	#1 well	0.4	
21	5:45	#1 well	0.4	
22	5:30	#1 well	0.4	
23	2:00	#1 well	0.4	
24	4:00	#1 well	0.4	
25	10:15	#1 well	0.4	
26	6:10	#1 well	0.5	
27	6:30	#1 well	0.5	
28	11:00	#1 well	0.4	
29	8:30	#1 well	0.5	
30	3:00	#1 well	0.4	
31	5:30	#1 well	0.4	

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.

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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Attach those results and submit them with this form.	Did continuous monitoring equipment fail at any time this reporting month? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 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 checked="" type="checkbox"/> No Attach grab sample results and submit them with this form.	Date continuous monitoring equipment failed: _____ / _____ / _____ Date it was returned to service: _____ / _____ / _____

Printed Name: *Steven Krupicka* Title: *water tester* Operator Certification #: _____
 Signature: *Steven Krupicka* Phone #: *(541) 210 2984* OR
 Date: *03/05/2024* *541 951 3901* Small Groundwater System

Return by 10th of following month by either email dwp.dmce@state.or.us; fax 971-673-0694;

Received Time Mar. 5. 2024 10:18 AM No. 0179, PO Box 14350, Portland, OR 97203-0350.

August 22, 2019