

Monthly Disinfection Report for Ground Water Systems

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

PWS ID# *4101165*

Month/Year *06/22* Entry Point: *well House*

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 | 2:30 | #1 well | 1.85 | |
| 2 | 9:30 | #1 well | 1.90 | |
| 3 | 1:00 | #1 well | 1.40 | |
| 4 | 7:00 | #1 well | 1.60 | |
| 5 | 9:30 | #1 well | 1.90 | |
| 6 | 9:00 | #1 well | 1.80 | |
| 7 | 10:00 | #1 well | 1.60 | |
| 8 | 6:00 | #1 well | 1.25 | |
| 9 | 7:00 | #1 well | 1.20 | |
| 10 | 6:20 | #1 well | 1.40 | |
| 11 | 5:45 | #1 well | 1.35 | |
| 12 | 5:30 | #1 well | 1.25 | |
| 13 | 3:00 | #1 well | 1.40 | |
| 14 | 7:10 | #1 well | 1.40 | |
| 15 | 5:15 | #1 well | 1.25 | |
| 16 | 7:40 | #1 well | 1.35 | |
| 17 | 8:00 | #1 well | 1.45 | |
| 18 | 7:50 | #1 well | 1.35 | |
| 19 | 5:30 | #1 well | 1.30 | |
| 20 | 8:00 | #1 well | 1.40 | |
| 21 | 6:35 | #1 well | 1.35 | |
| 22 | 4:35 | #1 well | 1.45 | |
| 23 | 6:00 | #1 well | 1.40 | |
| 24 | 3:30 | #1 well | 1.40 | |
| 25 | 9:00 | #1 well | 1.45 | |
| 26 | 8:30 | #1 well | 1.30 | |
| 27 | 6:10 | #1 well | 1.30 | |
| 28 | 5:40 | #1 well | 1.40 | |
| 29 | 2:00 | #1 well | 1.45 | |
| 30 | 1:15 | #1 well | 1.45 | |
| 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.

| | | |
|--|--|---|
| <p>GWS Serving 3,300 or Fewer</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>GWS Serving More Than 3,300</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> |
|--|--|---|

Printed Name: *Steve Krepicko* Title: *Water Tester* Operator Certification #: _____
 Signature: *Steve Krepicko* Phone #: *(541) 899-7189* OR _____
 Date: *07107122* Small Groundwater System

Return by 10th of following month by either email dwp.dmce@state.or.us; fax 971-673-0894; or mail to Drinking Water Services, PO Box 14350, Portland, OR 97293-0350.