

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

System Name Vintage Ruckles Water

PWS ID# 4 1 01532

Month/Year Oct / 21 Entry Point: Well House- Post Chlorination Required Minimum Residual 0.2 mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	11:00	Well	.86	5638
2	10:30		.84	5665
3	9:30		.78	5691
4	8:16		.80	5721
5	3:38P		.85	5759
6	9:05		1.07	5778
7	11:53		.92	5815
8	10:16		.74	5841
9	8:35		.48	5868
10	8:57		.63	5898
11	10:30		.80	5930
12	10:15		.55	5960
13	10:27		.59	5954
14	11:04		.69	6025
15	11:02		.89	6059
16	11:20		1.10	6106
17	11:40		.97	6136
18	1:45		.90	6168
19	11AM		1.08	6198
20	11:20A		1.02	6232
21	11:00A		1.27	6205
22	11:05A		1.15	6191
23	12:10P		1.44	6331
24	12:40P		.98	6357
25	11:AM		1.00	6384
26	2 PM		1.13	6416
27	12 N		.85	6444
28	1 PM		.54	6473
29	3 PM		.92	6510
30	12:30		.97	6534
31	12-		1.13	6576

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Data Mgmt & Compliance
Drinking Water Program

Was the chlorine residual ever less than the required minimum residual of 0.2 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>
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Printed Name: FAT O'BRIEN Title: _____ Operator Certification #: _____
 Signature: Fat O'Brien Phone #: (530) 353 5720 OR _____
 Date: 11 / 1 / 21 Small Groundwater System

Return by 10th of following month by either email dwp.dmce@state.or.us; fax 971-673-0694; or mail to Drinking Water Services, PO Box 14350, Portland, OR 97293-0350.