

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

System Name **BEAR MOUNTAIN RV PARK**

PWS ID# **41 91544**

Month/Year **6/2023** Entry Point: **Well**

Required Minimum Residual **1.2 mg/L**

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes	
				Chlorine Pump	Site #
1	4:20P	Faucet Well House	1.33	3.50	1.20
2	12:50P	"	1.27	3.50	1.05
3	3:30P	"	1.63	3.25	1.08
4	3:50P	"	1.30	3.50	1.16
5	3:45P	"	1.37	3.50	1.21
6	4:30P	"	1.34	3.50	1.11
7	4:05P	"	1.34	3.50	1.36
8	11:40A	"	1.27	3.50	1.21
9	3:25P	"	1.36	3.50	1.25
10	3:40P	"	1.40	3.50	1.18
11	12:05P	"	1.39	3.50	
12	3:35P	"	1.36	3.50	
13	11:35A	"	1.33	3.50	Added New chl.
14	4:55P	"	1.45	3.50	
15	1:35P	"	1.49	3.25	
16	2:45P	"	1.70	3.00	
17	5:15P	"	1.67	3.00	
18	12:45P	"	1.59	3.00	
19	4:20P	"	1.56	3.00	
20	1:00P	"	1.54	2.75	
21	1:45P	"	1.47	2.75	
22	4:50P	"	1.38	2.75	
23	5:20P	"	1.36	2.75	
24	3:15P	"	1.32	2.75	
25	1:00P	"	1.33	2.75	
26	2:55P	"	1.32	2.75	
27	9:40A	"	1.33	2.75	
28	5:30P	"	1.34	2.75	
29	3:25P	"	1.30	2.75	
30	3:55P	"	1.26	3.25	
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Was the chlorine residual ever less than the required minimum residual of 1.2 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><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 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: **ANTHONY SORGAARD** Title: **Co-OWNER** Operator Certification #: \_\_\_\_\_  
 Signature: *[Signature]* Phone #: **(503) 878-2400** OR  
 Date: **07/01/2023** Small Groundwater System

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; or mail to Drinking Water Services, PO Box 14350, Portland, OR 97293-0350.