

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

System Name **RAINEYS CORNER** PWS ID# 41 **94386**
 Month/Year **7/21** WTP-A Req'd Min Residual mg/L **0.4**

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	9:05 AM	ultiditusink	40	
2	6:30 AM		40	
3	7:00 AM		40	
4	6:50 AM		41	
5	7:15 AM		40	
6	6:30 AM		40	
7	7:00 AM		40	
8	8:30 AM		40	
9	8:00 AM		41	
10	8:20 AM		41	
11	7:15 AM		40	
12	8:30 AM		40	
13	9:00 AM		40	
14	8:45 AM		40	
15	9:45 AM		40	
16	6:30 AM		40	
17	7:15 AM		41	
18	6:45 AM		40	
19	8:00 AM		40	
20	6:45 AM		40	
21	6:30 AM		40	
22	7:15 AM		40	
23	7:30 AM		40	
24	6:15 AM		40	
25	8:10 AM		40	
26	7:30 AM		40	
27	8:00 AM		40	
28	7:45 AM		40	
29	6:15 AM		41	
30	8:10 AM		40	
31	8:20 AM		40	

Was the chlorine residual ever less than the required minimum residual of 0.4 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 checked="" 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 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: _____ / _____ / _____ Date it was returned to service: _____ / _____ / _____</p>
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Printed Name: Christa Rainey Title: SEC Operator Certification #: _____
 Signature: Christa Rainey Phone #: 826 1541 5421 OR