

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

System Name MR RASCALS PWS ID# 41 95377
 Month/Year Sept 21 Entry Point: A 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		.4	
2	11:30		.4	
3	11:30		.4	
4	11:30	Kitchen	.4	
5	11:30		.4	
6	3:30		.4	
7	6pm		.4	
8	11:45		.4	
9	11:45		.4	
10	11:30		.4	
11	11:30	.4		
12	11:30	.4		
13	3:00	.4		
14	6pm	.4		
15	11:45	.4		
16	1pm	.4		
17	11:30	.4		
18	11:30	.5		
19	11:30	.5		
20	3:00	.5		
21	6pm	.5		
22	noon	.5		
23	11:30	.5		
24	11:45	.5		
25	11:45	.5		
26	noon	.5		
27	3:15	.5		
28	6pm	.5		
29	noon	.5		
30	11:45	.5		
31				

Was the chlorine residual ever less than the required minimum residual of .2 mg/L? Yes No
 If yes, what was the longest time period until the required level was restored? _____ hours

<p>GWS Serving 3,300 or Fewer</p> <p>If yes, did you monitor every four hours until the residual returned to _____ mg/L? <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? <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: EDWARD BORTA Title: OWNER Operator Certification #: _____
 Signature: [Signature] Phone #: (541) 846-9203 OR N/A
 Date: 9/16/21 Small Groundwater System