

GROUNDWATER MONTHLY OPERATION REPORT IOWA DNR WATER SUPPLY

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Facility Name: _____

PWSID Number: _____

Treatment Plant #: _____ S/EP #: _____

Month: _____ Year: _____

D a y	Pumpage	Quantity Used lbs. or gals. (circle one)	Chlorine								Fluoride		Other		D a y	
	to system in thousands of gallons		Free Chlorine (mg/L)				Total Chlorine (mg/L)				Quantity Used lbs. or gals. (circle one)	Raw (mg/L)	S/EP (mg/L)			
			At Plant		In System		At Plant		In System							
			# of Tests	Avg.	# of Tests	Avg.	# of Tests	Avg.	# of Tests	Avg.						
1															1	
2															2	
3															3	
4															4	
5															5	
6															6	
7															7	
8															8	
9															9	
10															10	
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12															12	
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25															25	
26															26	
27															27	
28															28	
29															29	
30															30	
31															31	
Total																Total
Avg.																Avg.
Max.																Max.
Min.																Min.

Percentage of available chlorine in compound applied: _____ %

I certify that I am familiar with the information contained in this report and that the information is true, complete, and accurate.

DRC Operator or Designee's Signature: _____

Certificate #: _____ Grade: _____ Date: _____

