

**SURFACE WATER/INFLUENCED GROUNDWATER MONTHLY OPERATION REPORT
IOWA DNR WATER SUPPLY
Basic Information**

S/EP: _____

System Name: _____

PWSID #: _____

Month: _____

Year: _____

D a y	Operating Hours	Pumpage		Fluoride		Raw Turbidity	Settled Turbidity (individual sed basin)							
	Number of hours the plant operated per day.	Raw in 1,000s Gallons Per Day	To System in 1,000s Gallons Per Day	Quantity Used in lbs. or gls. (circle one)	Finished Water (mg/L)	Highest Daily Reading (NTU)	Highest Daily Reading Sed 1 (NTU)	Highest Daily Reading Sed 2 (NTU)	Highest Daily Reading Sed 3 (NTU)	Highest Daily Reading Sed 4 (NTU)				
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28														
29														
30														
31														
Total														
Avg														
Max														
Min														

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: _____

**SURFACE WATER/INFLUENCED GROUNDWATER MONTHLY OPERATION REPORT
IOWA DNR WATER SUPPLY
Disinfection/Oxidation Data Page**

S/EP: _____

System Name: _____

PWSID #: _____

Month: _____

Year: _____

Day	Chlorine Residual							CT	Chlorine Dioxide	Chlorite	Quantity of Disinfectant Used	
	Source/Entry Point (S/EP)			Distribution							Ratio of CT Obtained to CT Required ***	At S/EP** (mg/L)
	Number of Tests Taken*	Specify Free (F) or Total (T)	Lowest Measured Residual (mg/L)	Continuous Hours Less than 0.3 mg/L Free or 1.5 mg/L Total	Number of Tests Taken	Lowest Measured Residual (mg/L) Circle One T or F	Number with Undetected Residual	Highest Measured Residual (mg/L)				
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30												
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Total												
Avg												
Max												
Min												

*If continuous monitoring of chlorine is provided, enter "C" in the space provided.

**If chlorine dioxide MRDL of 0.8 mg/L or daily chlorite MCL of 1.0 mg/L is exceeded, then "Chlorine Dioxide/Chlorite Supplemental Monitoring Form" must be completed.

***Must be calculated daily and the Ratio of CT Obtained to CT Required must be greater than or equal to 1.0 one a daily basis.

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: _____

**SURFACE WATER/INFLUENCED GROUNDWATER MONTHLY OPERATION REPORT
IOWA DNR WATER SUPPLY
Turbidity Data**

S/EP: _____

System Name: _____

PWSID #: _____

Month: 0

Year: _____

Day	Combined Filter Effluent			Individual Filter Effluent															
	Number of Readings Taken*	Number of Readings >0.3 NTU	Highest Daily Reading (NTU)	#1		#2		#3		#4		#5		#6		#7		#8	
				Daily Highest (NTU)	# of Consec Results >1.0 NTU	Daily Highest (NTU)	# of Consec Results >1.0 NTU	Daily Highest (NTU)	# of Consec Results >1.0 NTU	Daily Highest (NTU)	# of Consec Results >1.0 NTU	Daily Highest (NTU)	# of Consec Results >1.0 NTU	Daily Highest (NTU)	# of Consec Results >1.0 NTU	Daily Highest (NTU)	# of Consec Results >1.0 NTU	Daily Highest (NTU)	# of Consec Results >1.0 NTU
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29																			
30																			
31																			
Total																			
Avg.																			
Max.																			
Min.																			

*If continuous monitoring of turbidity is provided, measurements must be recorded at equal time intervals at least once every four hours.

I certify that I am familiar with the information contained in this report and that, to the best of my knowledge, the information is true, complete, and accurate.

DRC Operator or Designee's Signature: _____

Certificate #: _____ Grade: _____ Date: _____

**SURFACE WATER/INFLUENCED GROUNDWATER MONTHLY OPERATION REPORT
IOWA DNR WATER SUPPLY**

Summary
Page 1 of 2

S/EP: _____
SYSTEM NAME: _____ **PWSID #:** _____ **MONTH:** _____ **YEAR:** _____

1. DISINFECTANT RESIDUAL ENTERING THE DISTRIBUTION SYSTEM:

- a. How many times did the residual disinfectant concentration of the water ENTERING the distribution system fall below 0.3 mg/L of free chlorine, or 1.5 mg/L of total chlorine for more than 4 hours?
- b. Date and duration of each occurrence:

Date	Duration (Hours)	Date and Time DNR Notified	Person Notified

2. DISINFECTANT RESIDUAL WITHIN THE DISTRIBUTION SYSTEM:

- a. Number of times that the disinfectant residual was measured in the system:
- b. Number of times the disinfectant residual **WAS NOT** measured but where the HPC was measured:
- c. Number of times the disinfectant residual was measured but **NOT** detected and no HPC was measured:
- d. Number of times the disinfectant residual was measured but **NOT** detected and the HPC was greater than 500/ml:
- e. Number of times where the disinfectant residual **WAS NOT** measured and the HPC was greater than 500/ml:

From above Calculate $V = [(C+D+E) / (A+B)] \times 100\%$: %
 For last month, V was: %
 (V must not exceed 5% for any two consecutive months)

3. CALCULATION OF MAXIMUM RESIDUAL DISINFECTANT LEVEL (MRDL):

Calculation of maximum disinfectant residual is based on the monthly average of the Total chlorine residual measured at the same time compliance bacterial samples are collected (this includes repeat/check samples but excludes specials). The RAA must be calculated at the end of each calendar quarter and include the previous 12 months.

	1	2	3	4	5	6	7	8	9	10	11	12
Actual Month/Year:												
# of samples used in calc.:												
Monthly Avg.:												
	Running Annual Average (RAA)*: <input type="text"/>											

*Should be less than the MRDL of 4.0 mg/L

4. FINISHED WATER TURBIDITY:

- a. Number of turbidity readings taken:
- b. Number of Readings greater than 0.5 NTU:
- c. Percent of readings less than or equal to 0.5 NTU: %
- d. Specify date and duration of any turbidity measurement greater than 5 NTU:

Date	Duration (Hours)	Date and Time DNR Notified	Person Notified

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DRC Operator or Designee's Signature: _____

Certificate #: _____ Grade: _____ Date: _____

**SURFACE WATER/INFLUENCED GROUNDWATER MONTHLY OPERATION REPORT
IOWA DNR WATER SUPPLY**

Summary
Page 2 of 2

5. INDIVIDUAL FILTER EFFLUENT PERFORMANCE SUMMARY

Criteria	Filter No.							
a. Number of days with event(s) above 1.0 NTU this month								
b. Number of days with event(s) above 1.0 NTU last month								
c. Number of days with event(s) above 1.0 NTU two month ago								
d. Total number of days with event(s) above 1.0 NTU in three months								
e. Number of days with event(s) above 2.0 NTU this month								
f. Number of days with event(s) above 2.0 NTU last month								

For events documented in Item a, an explanation of cause of the event must be provided.

For events documented in Items a, b & c, a self-assessment report must be prepared within 14 days.

Date Tiggered: Date Completed:

For events documented in Item f, a Comprehensive Performance Evaluation by the Department or its designee is required within 30 days.

NOTE: An "event" is considered to be two consecutive turbidity readings taken 15 minutes apart.

SURFACE WATER/INFLUENCED GROUNDWATER MONTHLY OPERATION REPORT

IOWA DNR WATER SUPPLY

Chlorine Dioxide/Chlorite Supplemental Monitoring Page

S/EP: _____

SYSTEM NAME: _____

PWSID #: _____

MONTH: _____

YEAR: _____

Monthly Chlorine Dioxide Daily MRDL Exceedance

NOTE: This monitoring must follow the written sampling plan.

Event:	1	2	3	4	5	6
Date S/EP sample exceeded 0.8 mg/L:						
Measured Level:						

Event	Following days results:	Date	Time	Location	Level	Was MRDL Exceeded? (Yes/No)	Non-acute Violation (Yes/No)	Acute Violation* (Yes/No)
1	Source/Entry Point:			S/EP				
	Distribution (3):							
2	Source/Entry Point:			S/EP				
	Distribution (3):							
3	Source/Entry Point:			S/EP				
	Distribution (3):							
4	Source/Entry Point:			S/EP				
	Distribution (3):							
5	Source/Entry Point:			S/EP				
	Distribution (3):							
6	Source/Entry Point:			S/EP				
	Distribution (3):							

*For each **Acute** violation event, provide the following information:

Event:	1	2	3	4	5	6
Date & Time DNR Notified:						
Person Notified:						

Monthly Chlorite Daily MCL Exceedance

Did daily S/EP monitoring exceed MCL of 1.0 mg/L (Yes or No)?	
Were three distribution samples collected the following day (Yes or No)?	
What was the average of the three distribution samples?	
Was a non-acute MCL violation incurred (Yes or No)?	

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DRC Operator or Designee's Signature: _____

Certificate #: _____

Grade: _____

Date: _____

**SURFACE WATER/INFLUENCED GROUNDWATER MONTHLY OPERATION REPORT FORM
IOWA DNR WATER SUPPLY**

Alternative Compliance Criteria Report Page 1 of 2

S/EP #: _____
 System Name: _____ PWSID #: _____ Month: _____ Year: _____

This Alternative Compliance Criteria (ACC) Report is being submitted to request the following ACC: (check one)

#1 #2 #3 #4 #5 #6 #7 #8

#1	Source Water TOC less than 2.0 mg/L? (calculated quarterly as a running annual average)												
	Actual Month/Yr	1	2	3	4	5	6	7	8	9	10	11	12
	Monthly TOC												
	RAA												

#2	Treated Water TOC less than 2.0 mg/L? (calculated quarterly as a running annual average)												
	Actual Month/Yr	1	2	3	4	5	6	7	8	9	10	11	12
	Monthly TOC												
	RAA												

#3	Source Water TOC less than 4.0 mg/L? (calculated quarterly as a running annual average)												
	AND Source water alkalinity over 60 mg/L (as CaCO3)? (calculated quarterly as a running annual average)												
	Actual Month/Yr	1	2	3	4	5	6	7	8	9	10	11	12
	Monthly TOC												
	RAA TOC												
	Monthly Alkalinity												
	Avg. RAA Alkalinity												
	Max. <u>Min.</u>	Yearly Average TTHM: <input type="text"/> mg/L						Yearly Average HAA5: <input type="text"/> mg/L					

ATTACH COPY OF COMPLIANCE REPORT FOR DISINFECTION BY-PRODUCTS (TTHM AND HAA5)

#4	TTHM and HAA5 no greater than 0.040 mg/L and 0.030 mg/L, respectively?												
	Yearly Average TTHM: <input type="text"/> mg/L						Yearly Average HAA5: <input type="text"/> mg/L						
	ATTACH COPY OF COMPLIANCE REPORT FOR DISINFECTION BY-PRODUCTS (TTHM AND HAA5)												

AND only chlorine is used in the whole plant and distribution system.
 I certify that for the last 12 months, only free chlorine was used as a disinfectant for primary disinfection and for maintenance of a residual in the distribution system.

 Certified Operators Signature: Certification #: _____ Date: _____

#5	Source water SUVA less than or equal to 2.0 L/mg-m? (calculated quarterly as a running annual average)												
	(Source water SUVA is the ultraviolet light absorption at 254 nanometers divided by the dissolved organic carbon concentration in the source water before any treatment of any kind. Measure monthly.)												
	Actual Month/Year	1	2	3	4	5	6	7	8	9	10	11	12
	Monthly SUVA												

RAA SUVA

#6	Treated water SUVA less than or equal to 2.0 L/mg-m? (calculated quarterly as a running annual average)												
	(Treated water SUVA is the ultraviolet light absorption at 254 nanometers in the finished water divided by the dissolved organic carbon concentration before any disinfection of any kind. Measured monthly)												
	Actual Month-Year	1	2	3	4	5	6	7	8	9	10	11	12
	Monthly SUVA												

RAA SUVA

SURFACE WATER/INFLUENCED GROUNDWATER MONTHLY OPERATION REPORT FORM
IOWA DNR WATER SUPPLY
 Alternative Compliance Criteria Report Page 2 of 2

System must be practicing Softening for use of ACC #7 & #8

#7	Treated water alkalinity less than 60 mg/L (as CaCO3)? (calculated quarterly as a running annual average)												
	Actual Month-Year	1	2	3	4	5	6	7	8	9	10	11	12
	Monthly Treated Alkalinity												
	RAA Treated Alk.												
	AND cannot achieve the Step 1 TOC removal												
	Step 1 Compliance Summary:												

TOC % Removal Summary		
TOC % Removal	Requirement	TOC Removal Ratio

#8	Magnesium hardness removal greater than or equal												
	Actual Month-Year	1	2	3	4	5	6	7	8	9	10	11	12
	Monthly Raw Mg. Hardness												
	Monthly Treated Mg. Hardness												
	Monthly Mg Removal												
	RAA Mg Removal												

TOC % Removal Summary		
TOC % Removal	Requirement	TOC Removal Ratio

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: _____