



SECTION OF DRINKING WATER PROTECTION
Fluoridation Monthly Report (Less Than 3300)

See Instructions on Reverse Side to Complete Form

PWS ID#	Month of
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Name of Facility	Street	
City	Zip Code	County (Optional)
Operator Name (Please Print)	Title	Phone #
Fluoride Chemical Used	Raw Water Fluoride Concentration mg/L	Water Source

I certify that the information on this report is correct and that the water treatment plant was operated in accordance with the provisions and operational parameters established by the Minnesota Department of Health.

Signature	Date
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Date	Meter Reading (1000 gal.)	Pumpage (1000 gal.)	Amount of Solution or Compound Used (gal./lbs.)	Fluoridation Analysis	
				Tested Fluoride Concentration (mg/L)	Sampling Point on Distribution System
Week	1	2	3	4	5
1					
2					
3					
4					
5					

**INSTRUCTIONS FOR FILLING OUT THE
FLUORIDATION MONTHLY REPORT (LESS THAN 3300)**

**Column
Number**

- 1** **Weekly (at least) water meter reading in thousands of gallons.**

- 2** **Pumpage in thousands of gallons: current meter reading minus the previous meter reading.**

- 3** **The total number of gallons of fluoride solution used or the total pounds of fluoride compound used if you are using sodium silicofluoride.**

- 4** **Your tested fluoride concentration of the treated water. These tests are to be performed at least once each calendar week. Do not composite samples.**

- 5** **Sample location: the sample is to be taken on the distribution system and at different locations each time.**

NOTE: THE RAW WATER FLUORIDE CONCENTRATION SHOULD BE TESTED MONTHLY.

COMMENTS: _____

Send Fluoridation Monthly Report (Less Than 3300) to:

**Minnesota Department of Health
Community Water Supply Unit
P.O. Box 64975
St. Paul, MN 55164-0975**