County of Santa Cruz

Health Services Agency - Environmental Health

701 Ocean Street, Room 312, Santa Cruz, CA 95060

(831) 454-2022 TDD/TTY - Call 711 http://www.scceh.org

Disinfection Byproduct (DBP) Monitoring Plan

I. System Information:

Water System Name		Water System #	
Water System Address			
Water System Classification	☐ Community ☐ Nontransient-Noncommunity		
Service Connection #		Population Served	
Number of Water Sources		Number of Treatment Systems	
Type of Disinfection *(Chlorine, Ozone)*		Number of Treated Water Storage Tanks	

II. Ozone: Bromate Monitoring

Does your system utilize Ozone disinfection? ☐ Yes ■ No

If no, skip to Section III for chlorine DBP monitoring.

If yes, how frequently must your water system monitor for Bromate? ☐ Month ☐ Quarter*

Bromate must be monitored immediately after treatment, prior to entry into the distribution system.

Treatment System Effluent Location	
Monitoring Location PS- Code	
Monitoring Location Description	

**Quarterly if bromate RAA ≤0.0025 mg/L, Monthly if bromate RAA >0.0025 mg/L or source water bromide RAA ≥ 0.05 mg/L)*

III. Chlorine: TTHM / HAA5 Monitoring

Does your system utilize chlorine (Sodium Hypochlorite) disinfection? ☐ Yes ■ No

If no, return to Section II for Ozone sampling requirements.
If yes, what is your monitoring period for TTHM/HAA5? ☐ Quarter ☐ Year ☐ 3 Years *

TTHM/HAA5 must be monitored in the distribution system in the location with maximum residence time, in the month with the warmest temperature for that monitoring period.

Monitoring Location Address	
Monitoring Location PS- Code	
Monitoring Location Description	
Month(s) to Monitor this Location	

If more than one treatment system is listed in the System Information section, a monitoring location must be identified for each one.

Monitoring Location Address	
Monitoring Location PS- Code	
Monitoring Location Description	
Month(s) to Monitor this Location	

Monitoring Location Address	
Monitoring Location PS- Code	
Monitoring Location Description	
Month(s) to Monitor this Location	

Monitoring Location Address	
Monitoring Location PS- Code	
Monitoring Location Description	
Month(s) to Monitor this Location	

*Monitoring frequency is determined based on past monitoring results. (22 CCR § 64534.2)

Chlorine residuals must be collected at the same time as bacteriological samples and included on the report.

VI. Purchased Water Contact Information

Does the water system obtain potable water from another water system? ☐ Yes ■ No

If yes, contact the wholesaler if any DBP exceeds the MCL..

Wholesaler Name	
Wholesaler Contact Person	
Contact Phone Number	

VII. Personnel and Laboratory Notification

Sampler Name			
Sampler Day/Evening Phone			
Sampler Email			
Alternate System Contact		Phone Number	
Laboratory Name			
Laboratory phone number		State Lab Code	

The system must report the results to Santa Cruz County Environmental Health Division by the 10th of the month immediately following the end of the monitoring period.

Santa Cruz County Environmental Health Division contact information:

Nathan Salazar, DI, REHS – Drinking Water Program (831) 359-0856 Evening: (831) 345-1382

County of Santa Cruz Health Services Agency, Environmental Health Division (831) 454-2022 (day or night, leave message)

VIII. Map or Diagram

A map of the distribution system is required to show all monitoring locations, source location (well, spring, etc.), storage tanks, treatment facilities, and distribution piping (pressure zones, booster stations, pressure reducing stations, and dead ends).

A distribution map is attached: ☐ Yes ☐ No

IX. Prepared by

System Representative Name	
System Representative Title	

Signature:_____ Date: _____

X. DBP Monitoring Plan Approval

The EHD has reviewed and approved this DBP Monitoring Plan. Any plans on file dated prior to approval of this plan are void. Per the California Code of Regulations-Title 22 §64534.8, a water system is required to submit an updated plan to the County any time the plan no longer ensures representative monitoring of the system.

EHD Representative Name	
EHD Representative Title	

Signature:_____ Date: _____

KEEP A COPY OF THIS FORM FOR YOUR REFERENCE AND USE