

MASS/DEPARTMENT OF PUBLIC HEALTH DAILY FLUORIDATION REPORT

Month of _____ Year _____ Page _____ of _____ (Use the same form daily for one month for each source or manifolded or combined sources)

Section I. PWS INFORMATION:

1. PWS Name: _____ 2. PWS ID# : _____ 3. City/Town or District: _____
4. Source(s) Fluoridated/MassDEP Source Code/Location ID: _____
5. Is the Source(s) Manifold? Yes No List location or Mass DEP location ID# for the daily sample: _____

Section II. PWS CHEMICAL USE INFORMATION:

1. Type of fluoride chemical used: NaF Na₂SiF₆ H₂SiF₆
2. What is the purity of the fluoride chemical? _____ % (From shipping container or hydrometer test rounded to nearest unit).
3. Are all fluoride-metering pumps protected by two (2) operating anti-siphon (back-pressure) valves? Yes No
4. Was each anti-siphon valve disassembled and inspected in the last 12 months? Yes Date: _____ No
 Explain: _____
5. Was the fluoride test meter calibrated each day before use? (See Note 2) Yes No
 Explain: _____
6. Do you require on site technical assistance? Yes No If yes, explain: _____

Section III. DAILY RESULT:

Days of the Month	Gallons of Water Treated (to the nearest 1,000 gallons)	Amt. Fluoride Added (Lbs)	Saturator 1 Volume of Make Up Water Added <input type="checkbox"/> Gals or <input type="checkbox"/> Cu Ft	Calculated Fluoride Ion Dosage (ppm)	Results of Fluoride Tests by PWS (ppm) ^{2,3}	Name of tester and Comments E.g. Reason(s) for not fluoridating or sampling. Changes in product or batch mixing day etc.
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30						
31						
Totals						If you use a saturator: calculate monthly Fluoride Ion Dosage _____ ppm
Average						

- Notes:** 1) If you use a saturator you must calculate a monthly fluoride ion dosage based on pounds used.
 2) If you use a Mass. certified lab. for daily sampling, attach a copy of your Mass. approved lab analytical report form to this report.
 3) All pumping fluoridated sources **MUST** be tested daily for fluoride at the entry point to the distribution system or near the point of fluoride application.
 4) The optimum fluoride level (average) is 1.0 ppm with a permissible range of **0.9-1.2** ppm **5) Report all Fluoride results to the nearest tenth.**
6) For Fluoride issues that require reporting, notify DPH at 617-624-6074 **AND** MassDEP Drinking Water Program Regional Office or 617-292-5770.

I certify under penalty of law that I am the person authorized to fill out this form and the information contained herein is true, accurate and complete to the best of my knowledge and belief.

Name of PWS certified operator or responsible party: _____ Signature: _____ Date: _____
 Phone #: _____ Fax#: _____ Email address: _____

Section IV: DPH USE:

Date received: _____ Comments: _____

PWSs approved by MassDEP for Fluoridation treatment must return all applicable pages (A, B & C) of this report form **by the 10th day following the reporting month** to: MassDPH, 250 Washington Street-5th floor, Boston, MA 02108. Attention: Office of Oral Health DPH Fluoride Form A -5-24-07