MASS/DEPARTMENT OF PUBLIC HEALTH DAILY FLUORIDATION REPORT **DPH-FL-A (Daily)**

Month of ____Year of _____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) Manifolded? Yes ☐ or No ☐ 6. List the location **or** Mass DEP location ID# for the daily sample: _____

Section II. PWS CHEMICAL USE INFORMATION:

1. Type of fluoride used: NaF ☐ Na_2SiF_6 ☐ H_2SiF_6 ☐.
2. What is the purity of the fluoride compound? _____%. ***(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 _____ or No ☐ Explain: _____
5. Was the fluoride test meter calibrated each day before use? (See Note 2) Yes ☐ or No ☐ Explain: _____
6. Do you require on site technical assistance? Yes ☐ or No ☐ If yes, explain: _____

Section III. DAILY RESULT

DAYS of the month	**Gallons of Water Treated** (To nearest 1,000 gals)	**Amt. Fluoride Added** (lbs)	**Saturator [1] Volume of Make Up Water Added** Gals ☐ or Cu Ft ☐	**Calculated Fluoride Ion Dosage** (ppm)	**Results of Fluoride Test 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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Total						**If you use a Saturator:** Calculated 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 after the point of fluoride application.
4) The optimal fluoride level is 0.7 mg/L. **5) Report all Fluoride results to the nearest tenth.**
6) For Fluoride issues that require reporting, notify DPH at 617-624-5573 **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