

State of Oregon Drinking Water Program
Monthly Disinfection Report for Ground Water Systems

System Name Camelot Mobile Residence PWS ID# 41 00027
 Month/Year 9/22 Entry Point: Pumphouse Required Minimum Residual .5 mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	9:00	Pumphouse	.8	
2	9:00		.6	
3	9:00		.6	
4	9:00		.5	
5	9:00		.6	
6	9:00		.6	
7	9:00		.6	
8	9:00		.7	
9	9:00		.8	
10	9:00		1.0	
11	9:00		.6	
12	9:00		.8	
13	9:00		.8	
14	9:00		.9	
15	9:00		.8	
16	9:00		.7	
17	9:00		.8	
18	9:00		.8	
19	9:00		.6	
20	9:00		.7	
21	9:00		.6	
22	9:00		.7	
23	9:00		.7	
24	9:00		.6	
25	9:00		1.0	
26	9:00		.9	
27	7:00		.6	
28	9:00		.5	
29	9:00		.6	
30	9:00		.5	
31	—		—	—

Was the chlorine residual ever less than the required minimum residual of .5 mg/L? Yes No
 If yes, what was the longest time period until the required level was restored? _____ Hours – If > 4 hours, Drinking Water Program to be notified by end of next business day.

<p>GWS Serving 3,300 or Fewer</p> <p>If yes, did you monitor every four hours until the residual returned to <u>.5</u> mg/L as required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Attach those results and submit them with this form.</p>	<p>GWS Serving More Than 3,300</p> <p>Did continuous monitoring equipment fail at any time this reporting month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, were grab samples collected every four hours until the continuous monitoring equipment was returned to service as required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Attach grab sample results and submit them with this form.</p>
	<p>Date continuous monitoring equipment failed: _____/_____/____</p> <p>Date it was returned to service: _____/_____/____</p>

Printed Name: Wanda Gloude Title: Owner Operator Certification #: _____
 Signature: Wanda Gloude Phone #: (541) 926-2863
 Date: 10/6/22

OR
 Small Groundwater System