

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

System Name Camelot Mobile Residence PWS ID# 41 00027
 Month/Year 2/24 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	1.0	
2	9:00		1.0	
3	9:00		1.2	
4	9:00		1.2	
5	7:30		1.2	
6	7:30		1.2	
7	7:30		1.1	
8	7:30		1.2	
9	7:30		1.2	
10	8:46		1.2	
11	8:00		1.2	
12	7:30		1.2	
13	7:30		1.1	
14	7:30		1.1	
15	7:30		1.2	
16	7:30		1.2 1.2	
17	7:30		1.1 1.1	
18	9:00		1.0	
19	7:30		1.0	
20	7:30		1.0	
21	7:30		1.1	
22	7:30		1.1	
23	7:30		1.1	
24	9:30		1.0	
25	8:30		1.0	
26	7:30		1.0	
27	7:30		1.2	
28	7:30		1.1	
29	7:30		1.2	
30	—		—	
31	—		—	

Was the chlorine residual ever less than the required minimum residual of _____ 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 _____ 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>
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Printed Name: Wanda Gloude Title: Owner Operator Certification #: _____
 Signature: Wanda Gloude Phone #: (541) 926-2863 OR
 Date: 3/1/24 Small Groundwater System