

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

System Name Camelot Mobile Residence PWS ID# 41 00027
 Month/Year 6 124 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	11:00	Pumphouse	1.3	
2	9:00		1.2	
3	8:00		1.3	
4	8:00		1.2	
5	8:00		1.1	
6	8:00		0.9	
7	8:00		1.1	
8	9:00		1.4	
9	10:00		1.5	
10	8:00		1.4	
11	8:00		1.3	
12	8:00		1.2	
13	8:00		1.3	
14	8:00		1.2	
15	11:00		1.3	
16	12:00		1.2	
17	8:00		1.0	
18	8:00		1.1	
19	9:00		1.2	
20	12:00		1.3	
21	9:00		1.2	
22	9:00		1.3	
23	10:00		2.2	
24	9:00		2.0	
25	9:00		.8	
26	9:00		.9	
27	8:00		1.2	
28	10:00		1.4	
29	10:00		1.4	
30	10:00		1.2	
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> </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: _____/_____/_____ Date it was returned to service: _____/_____/_____</p>	

Printed Name: Wanda Gloude Title: Owner Operator Certification #: _____
 Signature: Wanda Gloude Phone #: (541) 926-2863
 Date: 7/1/24 OR
 Small Groundwater System