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

System Name **Camelot Mobile Residence** PWS ID# 4 1 **00027**

Month/Year ___/___ 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	10:00		.8	
2	9:00		.8	
3	9:00		.6	
4	7:00		.7	
5	7:00		.7	
6	9:00		.7	
7	9:00		.6	
8	9:00		.7	
9	7:00		.8	
10	8:00		.8	
11	8:00		.6	
12	8:00		.7	
13	8:00		.6	
14	8:00		.6	
15	8:00		.7	
16	7:00		.7	
17	8:00		.8	
18	8:00		.6	
19	8:00		.7	
20	10:00		.8	
21	10:00		.7	
22	10:00		.6	
23	9:00		.7	
24	10:00		.8	
25	10:00		.7	
26	12:00		.7	
27	10:00		.7	
28	10:00		.7	
29	7:00		.6	
30	8:00		.7	
31	8:00		.7	

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.

GWS Serving 3,300 or Fewer

If yes, did you monitor every four hours until the residual returned to ___ mg/L as required? ☐ Yes ☐ No

Attach those results and submit them with this form.

GWS Serving More Than 3,300

Did continuous monitoring equipment fail at any time this reporting month? ☐ Yes ☐ No

If yes, were grab samples collected every four hours until the continuous monitoring equipment was returned to service as required? ☐ Yes ☐ No

Attach grab sample results and submit them with this form.

Date continuous monitoring equipment failed:

___ / ____ / ____

Date it was returned to service:

___ / ____ / ____

Printed Name: **Wanda Gloude** Title: **Owner**

Signature: **Wanda Gloude** Phone #: **(541) 926-2863**

Date: **1/2/26**

Operator Certification #:_____

OR

Small Groundwater System ☐