

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

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

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: _____/_____/_____</p> <p>Date it was returned to service: _____/_____/_____</p>	

Printed Name: Wanda Gloude Title: Owner Operator Certification #: _____
 Signature: Wanda Gloude Phone #: (541) 926-2863 OR
 Date: 4/14/26 Small Groundwater System