

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

System Name Camelot Mobile Residence PWS ID# 41 00027

Month/Year 1/ 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	0.9	
2	9:00		1.0	
3	9:00		1.1	
4	9:00		1.1	
5	9:00		0.9	
6	9:00		1.0	
7	9:00		1.1	
8	9:00		1.0	
9	9:00		1.1	
10	9:00		0.9	
11	9:00		1.1	
12	9:00		1.0	
13	9:00		1.0	
14	9:00		1.1	
15	9:00		1.1	
16	9:00		1.1	
17	9:00		1.0	
18	9:00		1.0	
19	9:00		1.2	
20	9:00		1.1	
21	9:00		1.1	
22	9:00		1.2	
23	9:00		1.2	
24	9:00		1.1	
25	9:00		1.2	
26	9:00		1.2	
27	9:00		1.0	
28	9:00		1.2	
29	9:00		1.1	
30	9:00		0.9	
31	9:00		1.1	

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><i>Attach those results and submit them with this form.</i></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><i>Attach grab sample results and submit them with this form.</i></p>
	<p>Date continuous monitoring equipment failed: _____/_____/_____</p> <p>Date it was returned to service: _____/_____/_____</p>

Printed Name: Wanda Glouge Title: Owner Operator Certification #: _____
 Signature: Wanda Glouge Phone #: (541) 926-2863 OR
 Date: 2/4/24 Small Groundwater System