

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

System Name **Laurel Acres Water**

PWS ID# **41 00217**

Month/Year **02 121**

Entry Point: **WTP-A**

Required Minimum Residual **mg/L 0.3**

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1			.49	
2			.49	
3			.49	
4			.50	
5			.49	
6			.50	
7			.50	
8			.49	
9			.49	
10			.48	
11			.49	
12			.49	
13			.50	
14			.50	
15			.50	
16			.49	
17			.49	
18			.49	
19			.50	
20			.50	
21			.50	
22			.49	
23			.49	
24			.49	
25			.48	
26			.48	
27			.47	
28			.47	
29				
30				
31				

Was the chlorine residual ever less than the required minimum residual of 0.3 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: **Leo Jones**

Signature: **Leo Jones**

Date: **3 11 121**

Title: **SYSTEM OPERATOR**

Phone #: **503 19694415**

Operator Certification #:

OR

Small Groundwater System ☒