

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

System Name **Laurel Acres Water**

PWS ID# **41 00217**

Month/Year **April 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			.40	
2			.41	
3			.41	
4			.40	
5			.40	
6			.40	
7			.40	
8			.39	
9			.39	
10			.38	
11			.38	
12			.39	
13			.39	
14			.40	
15			.40	
16			.40	
17			.39	
18			.39	
19			.40	
20			.40	
21			.41	
22			.40	
23			.40	
24			.39	
25			.39	
26			.38	
27			.38	
28			.37	
29			.37	
30			.36	
31			.36	

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.

<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>Attach those results and submit them with this form.</p>	<p align="center">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: Leo Jones Title: Well Operator Operator Certification #: _____
 Signature: Leo Jones Phone #: 503 969-4415 OR
 Date: 5 14 121 Small Groundwater System