

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

System Name **Laurel Acres Water**

PWS ID# **41 00217**

Month/Year **June 2021** 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			.37	
2			.37	
3			.38	
4			.38	
5			.37	
6			.37	
7			.38	
8			.38	
9			.40	
10			.40	
11			.40	
12			.38	
13			.38	
14			.38	
15			.40	
16			.40	
17			.40	
18			.38	
19			.38	
20			.37	
21			.37	
22			.38	
23			.38	
24			.37	
25			.37	
26			.36	
27			.35	
28			.35	
29			.34	
30			.33	
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.

<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>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: **WATER OPERATOR** Operator Certification #: _____
 Signature: *Leo Jones* Phone #: **(503) 969-4415** OR
 Date: **6/11/2021** Small Groundwater System