

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



System Name LAURELWOOD WATER USERS CO-OP PWS ID# 41 00315  
 Month/Year 08 122 Entry Point: \_\_\_\_\_ Required Minimum Residual .2 mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	12:40P		.44	
2	7:22A		.38	
3	6:21		.44	
4	6:50		.52	
5	7:00A		.44	
6	6:14A		.51	
7	8:10A		.39	WEATHER REMAINS IN HIGH
8	8:11A		.33	340 3:30 (WILL RETEST) 90%
9	8:00A		.54	
10	7:AM		.52	
11	6:32A		.54	
12	8AM		.54	
13	7:21		.38	
14	12:44P		.43	
15	8:05A		.44	
16	7:27A		.49	
17	7:13A		.57	
18	7:24A		.60	
19	8:10A		.49	
20	6:36A		.74	
21	7:00A		.74	
22	9:29A		.79	8/31
23	9:05A		.74	4pm = .27
24	7:06A		.67	8pm = <del>.35</del> .35
25	8:20A		.67	
26	7:43A		.65	
27	8:23A		.56	
28	7:57A		.56	
29	8:45A		.30	LEAK-REPORTED IN PROGRESS
30	7:05A		.30	WILL MANUALLY DOSE TANK
31	8:05A		.20 .35	WILL RETEST 12PM - BOIL WATER REPORT

Was the chlorine residual ever less than the required minimum residual of .20 mg/L?  Yes  No *WILL CONTINUE ON SEPTALERT REPORT*  
 If yes, what was the longest time period until the required level was restored? 4 Hours - If > 4 hours, Drinking Water Program to be notified by end of next business day.

<p><b>GWS Serving 3,300 or Fewer</b></p> <p>If yes, did you monitor every four hours until the residual returned to <u>.20</u> mg/L as required? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Attach those results and submit them with this form.</p> <p><u>SEE ABOVE</u></p>	<p><b>GWS Serving More Than 3,300</b></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: _____/_____/_____                  Date it was returned to service: _____/_____/_____</p>	

Printed Name: JANE RUSSELL Title: \_\_\_\_\_ Operator Certification #: \_\_\_\_\_  
 Signature: Jane Russell Phone #: (503) 703 7379 OR  
 Date: 9/16/122 Small Groundwater System