State of Oregon Drinking Water Program

Monthly Disinfection Report for Ground Water Systems

System Name: LAURELWOOD WATER USERS COOP PWS ID#: 41 00315

Month/Year: 02/25 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	8:06 A		.95	
2	7:56 A		1.01	
3	4:08 P		.65	
4	7:04 A		.80	
5	7:55 A		1.	
6	6:40 A		.93	
7	7:45 A		.93	
8	8:04 A		.92	
9	8:02 A		.88	
10	8:17 A		1.02	
11	8:16 A		.97	
12	7:24 A		.83	
13	8:46 A		.86	
14	10:17 A		1.10	
15	7:52 A		1.26	
16	7:36 A		1.20	
17	7:42 A		1.16	
18	7:27 A		1.07	
19	8:27 A		1.28	
20	7:45 A		1.16	
21	8:01 A		1.04	BACTERIAL TEST TAKEN IN
22	7:47 A		1.11	
23	7:45 A		1.10	
24	7:16 A		1.14	
25	7:35 A		1.27	
26	7:06 A		.96	
27	9:00 A		.95	
28	7:34 A		.98	
29				
30				
31				

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.

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: JANE RUSSELL Title: _____

Signature: Jane Russell Phone #: (___) _____

Date: 03/03/25

Operator Certification #: _____

OR

Small Groundwater System ☐