State of Oregon Drinking Water Program

Monthly Disinfection Report for Ground Water Systems

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

Month/Year: 3/25 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	7:21 A		.91	
2	7:06 A		.89	
3	7:12 A		.89	
4	6:46 A		.93	
5	7:25 A		.90	
6	5:31 P		1.01	
7	6:16 A		.96	
8	7:36 A		.96	
9	6:42 A		.93	
10	5:50 P		.92	
11	8:27 A		1.12	
12	7:47 A		1.11	
13	4:15 P		1.05	
14	8:03 A		1.17	
15	8:09 A		1.07	
16	7:40 A		1.06	
17	6:45 A		1.03	
18	8:23 A		1.06	
19	7:22 A		.91	
20	7:25 A		.94	
21	8:42 A		.89	
22	7:41 A		.86	
23	6:50 A		.90	
24	8:13 A		.93	
25	8:06 A		.86	
26	8:01 A		.74	BAC TEST IN.
27	10:54 A		.78	
28	10:55 A		.79	
29	6:45 A		.81	
30	5:34 P		.88	
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 E Russell Phone #: (___) _____

Date: 03/02/25

Operator Certification #: _____

OR

Small Groundwater System ☐

December 19, 2012

SENT TO STATE 3/30/25