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: 4/25 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	9:06A		.97	
2	10:25A		.98	
3	7:59A		1.09	
4	7:35A		.77	
5	6:46A		.86	
6	7:53A		1.35	
7	6:45A		1.26	
8	10:13A		.98	
9	7:45A		.96	
10	7:42A		.77	
11	6:21A		.94	
12	7:05A		96	
13	8:42A		97	
14	8:29A		.95	
15	7:27A		.75	
16	6:42A		.75	
17	7:09Pm		.72	
18	7:06A		.70	
19	6:45A		.69	
20	8:55A		1.52	
21	9:20A		1.26	
22	8:06A		1.13	
23	9:05A		1.26	
24	9:46A		1.09	
25	8:06A		1.12	
26	8:09A		1.13	
27	8:22A		.91	
28	7:30A		1.51	
29	7:47A		.86	
30	9:55a	Bathroom Tub	.56	
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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.

LATE

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 #: (503) 703 7375

Date: 5/19/2025

Operator Certification #: _____

OR

Small Groundwater System ☐