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 5/25 Entry Point: NORTH SPRING 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	2 pm	Bathroom TUB	.42	
2	10:57A	SINK IN LAUNDRY RM	.47	
3	6:45A		.33	
4	7:35A		.34	
5	7:36A		.43	
6	7:14A		.46	
7	7:42A		.58	
8	8:19A		.82	
9	7:16A		1.17	
10	7:32A		1.06	
11	8:17		1.15	
12	8:46A		1.12	
13	9:04A		.96	
14	8:05A		.84	
15	8:14A		.72	
16	9:25A		.88	
17	7:38A		.82	
18	8:06A		.77	
19	6:05A		.72	
20	7:10A		.65	
21	7:15A		.70	
22	8:05A		.88	
23	7:31A		.97	
24	7:30A		.71	
25	7:01A		.74	
26	7:40A		.52	
27	7:06A		.64	
28	5:06AM		.68	
29	8:04A		.45	
30	6:44A		.56	BACTEST DELIVERED
31	8:22A		.56	

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 #: (503) 703 7379

Date: MAY 31, 2025

Operator Certification #: ____

OR

Small Groundwater System ☐