

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

System Name **FERN VALLEY ESTATES INPRV DISTRICT**

PWS ID# **41 00514**

Month/Year **DEC /2024**

Entry Point: **RESERVOIR**

Required Minimum Residual **0.20 mg/L**

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	7:30	Wells 2,3,4,5,and 6	0.81	
2	9:25		0.78	
3	9:15		0.71	
4	11:05		0.81	
5	8:10		0.79	
6	8:40		0.78	
7	9:00		0.85	
8	7:30		0.90	
9	8:50		1.04	
10	7:15		0.94	
11	8:05		0.97	
12	8:50		1.01	
13	9:55		1.06	
14	10:00		0.93	
15	12:40 PM		0.87	
16	7:30		0.77	
17	7:15		0.81	
18	11:50		0.68	
19	7:35		0.96	
20	11:40		0.91	
21	10:55		1.05	
22	9:35		0.91	
23	9:10		1.19	
24	11:55		0.91	
25	12:55 PM		0.99	
26	11:55		1.25	
27	4:10 PM		0.89	
28	12:50 PM		1.24	
29	12:52 PM		0.84	
30	3:16 PM		0.88	
31	12:50 PM		1.18	

Was the chlorine residual ever less than the required minimum residual of **0.2** mg/L? ☐ Yes ☒ No

If yes, what was the longest time period until the required level was restored?  
notified by end of next business day.

hours – If > 4 hours, Drinking Water Program to be

**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: **Mark Elias**

Title: **Systems Operator**

Operator Certification #:

Signature: *Mark Elias*

Phone #: (541) 840-0612

OR

Date: **1/16/25**

Small Groundwater System ☒

December 19, 2012