

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

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System Name Leafwood Water Assoc. PWS ID# 4100993 Certification Drinking Water Services
 Month/Year 2/23 Entry Point Source A Well 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	2:00 pm		4	
2	3:00 pm		4	
3	2:30 pm			
4	11:30 Am			
5	3:30 pm			
6	3:00 pm			
7	3:05 pm			
8	9:00 Am			
9	3:20 pm			
10	10:20 Am			
11	4:30 pm			
12	9:00 Am			
13	10:20 pm			
14	4:00 pm			
15	9:00 Am			
16	8:30 Am			
17	9:00 Am			
18	12:00 Am			
19	2:00 pm			
20	3:00 pm			
21	3:00 pm			
22	12:30 pm			
23	11:30 Am			
24	12:00 pm			
25	2:00 pm			
26	1:00 pm			
27	4:30 pm			
28	3:05 pm			
29				
30				
31				

Was the chlorine residual ever less than the required minimum residual of 2 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.

<p>GWS Serving 3,300 or Fewer</p> <p>If yes, did you monitor every four hours until the residual returned to _____ mg/L as required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Attach these results and submit them with this form.</p>	<p>GWS Serving More Than 3,300</p> <p>Did continuous monitoring equipment fail at any time this reporting month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, were grab samples collected every four hours until the continuous monitoring equipment was returned to service as required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Attach grab sample results and submit them with this form.</p>	<p>Date continuous monitoring equipment failed: _____</p> <p>Date it was returned to service: _____</p>
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Printed Name: Margaret Gargel Title: _____ Operator Certification #: N/A
 Signature: [Signature] Phone #: 541 946-7309 OR
 Date: 3/10/23 Small Groundwater System