

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

JAN 04 2024

System Name: Leafwood Water Assoc. PWS ID# 41 00993 Certification: Drinking Water Service
Month/Year: 12 / 23 Entry Point: Source AA 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	5:16	pm	.2	
2	4:00	pm	.2	
3	7:03	pm	.2	
4	9:26	pm	.2	
5	5:36	pm	.2	
6	3:50	pm	.2	
7	9:07	am	.2	
8	10:00	am	.2	
9	4:12	pm	.2	
10	4:34	pm	.2	
11	6:45	pm	.2	
12	5:47	pm	.2	
13	4:30	pm	.2	
14	5:15	pm	.2	
15	6:52	pm	.2	
16	9:02	pm	.2	
17	9:30	am	.2	
18	4:47	pm	.2	
19	5:20	pm	.2	
20	2:13	pm	.2	
21	4:49	pm	.2	
22	5:03	pm	.2	
23	5:47	pm	.2	
24	7:24	pm	.2	
25	4:00	pm	.2	
26	8:26	pm	.2	
27	7:21	pm	.2	
28	4:45	pm	.2	
29	1:16	pm	.2	
30	9:41	am	.2	
31	8:15	pm	.2	

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.

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 these 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: Allie Blanchard Title: _____
Signature: Allie Blanchard Phone #: (503) 521-6176
Date: 12 / 31 / 23

Operator Certification #: N/A
OR
Small Groundwater System