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Certification Drinking Water Services

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

System Name: Leaf Wood Water Assoc. PWS ID# 41 00993

Month/Year: 8/24 Entry Point: Source A 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	4:00	pm	.2	
2	4:00	pm	.2	
3	6:00	pm	.2	
4	2:30	pm	.2	
5	12:30	pm	.2	
6	12:30	pm	.2	
7	12:30	pm	.2	
8	1:30	pm	.2	
9	2:30	pm	.2	
10	2:00	pm	.2	
11	4:30	pm	.2	
12	7:30	pm	.2	
13	1:00	pm	.2	
14	5:00	pm	.2	
15	2:00	pm	.2	
16	6:00	pm	.2	
17	5:00	pm	.2	
18	7:00	pm	.2	
19	2:00	pm	.2	
20	10:00	Am	.2	
21	7:00	pm	.2	
22	10:30	Am	.2	
23		out of Town		
24				
25	3:00	pm	.4	
26	2:00	pm	.4	
27	12:30	pm	.2	
28	11:30	Am	.2	
29	9:00	Am	.2	
30	6:00	pm	.2	
31	3:00	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 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: M. Griggs Title: _____

Signature: M Griggs Phone #: 541 998 1309

Date: 8/31/24

Operator Certification #: N/A

OR

Small Groundwater System ☒