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

System Name: Leafwood Water Assoc. PWS ID#: 41 00993

Month/Year: 12/24 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	8:30	pm	.2	
2	6:00	pm	.2	
3	7:13	pm	.2	
4	9:00	pm	.2	
5	7:32	pm	.2	
6	9:30	pm	.2	
7	8:00	pm	.2	
8	5:30	pm	.2	
9	6:00	pm	.2	
10	7:05	pm	.2	
11	5:20	pm	.2	
12	7:15	pm	.2	
13	4:30	pm	.2	
14	4:50	pm	.2	
15	4:00	pm	.2	
16	8:30	pm	.2	
17	5:45	pm	.2	
18	7:50	pm	.2	
19	6:35	pm	.2	
20	2:15	pm	.2	
21	9:30	pm	.2	
22	4:00	pm	.2	
23	7:45	pm	.2	
24	8:15	pm	.2	
25	3:30	pm	.2	
26	4:40	pm	.2	
27	6:00	pm	.2	
28	5:15	pm	.2	
29	3:40	pm	.2	
30	5:50	pm	.2	
31	5:45	pm	.2	

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 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: AB Phone #: (541) 520-6026

Date: 12/31/24

Operator Certification #: _____

OR

Small Groundwater System ☐