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

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

Month/Year: 1 / 25 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	7:40	pm	.2	
2	2:00	pm	.2	
3	9:10	am	.2	
4	9:30	am	.3	
5	8:00	am	.3	
6	8:20	am	.3	
7	9:00	am	.2	
8	9:40	am	.2	
9	9:10	am	.2	
10	8:40	am	.2	
11	9:05	am	.3	
12	9:10	am	.3	
13	7:45	am	.3	
14	8:20	am	.3	
15	9:15	am	.3	
16	9:45	am	.3	
17	8:15	am	.3	
18	9:10	am	.3	
19	9:45	am	.3	
20	10:10	am	.3	
21	10:05	am	.4	
22	7:35	am	.4	
23	8:10	am	.4	
24	8:30	am	.4	
25	10:10	am	.4	
26	8:05	am	.4	
27	9:00	am	.4	
28	9:30	am	.4	
29	10:05	↓	.4	
30	9:10	↓	.4	
31	8:40	↓	.4	

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Certification Drinking Water Services

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 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: Alix Keller Title: _____

Signature: Alix Keller Phone #: (707) 5356536

Date: 1/31/25

Operator Certification #: N/A

OR

Small Groundwater System ☐