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: 3/25 Entry Point: Source/Well #1 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	AM	.4	
2	11:30	PM	.4	
3	2:00	PM	.4	
4	2:30	PM	.4	
5	4:00	PM	.4	
6	3:00	PM	.4	
7	9:30	AM	.4	
8	2:00	PM	.4	
9	10:30	AM	.4	
10	7:30	PM	.4	
11	5:00	PM	.4	
12	3:00	PM	.4	
13	3:00	PM	.5	
14	11:00	AM	.5	
15	5:30	PM	.4	
16	1:30	PM	.4	
17	2:30	PM	.4	
18	3:00	PM	.4	
19	12:30	PM	.4	
20	1:00	PM	.5	
21	1:00	PM	.5	
22	5:00	PM	.5	
23	11:30	PM	.5	
24	8:30	AM	.5	
25	2:30	PM	.4	
26	6:30	AM	.4	
27	1:00	PM	.4	
28	3:00	PM	.4	
29	5:00	PM	.5	
30	3:30	PM	.5	
31	1:00	PM	.5	

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: Margaret Gough Title: _____

Signature: _____ Phone #: 541 996 1309

Date: 4/2/25

Operator Certification #: N/A

OR

Small Groundwater System ☒