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

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

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

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Certification Drinking Water Services

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 Grubb Title: _____

Signature: _____ Phone #: 541 996-1309

Date: 5/1/25

Operator Certification #: N/A

OR

Small Groundwater System ☒