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

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

Month/Year: 6/25 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	4:27	pm	.2	
2	7:03	am	.1	
3	7:35	pm	.2	
4	5:49	pm	.3	
5	6:11	pm	.3	
6	3:36	pm	.2	
7	7:58	pm	.2	
8	4:12	pm	.2	
9	3:09	pm	.2	
10	6:34	pm	.2	
11	7:25	pm	.2	
12	5:16	pm	.2	
13	6:50	pm	.2	
14	3:57	pm	.2	
15	4:41	pm	.3	
16	8:30	pm	.2	
17	6:03	pm	.2	
18	7:40	pm	.2	
19	3:23	pm	.2	
20	5:01	pm	.2	
21	4:54	pm	.2	
22	3:45	pm	.2	
23	6:22	pm	.2	
24	4:00	pm	.3	
25	5:34	pm	.2	
26	7:50	pm	.2	
27	4:33	pm	.2	
28	3:18	pm	.2	
29	3:30	pm	.2	
30	5:48	pm	.2	
31				

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: Allie Blanchard Title: _____

Signature: AB Phone #: 541 520 1002 26

Date: 6/11/25

Operator Certification #: N/A

OR

Small Groundwater System ☑