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

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

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

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: M. Grugel Title: _____

Signature: [signature] Phone #: (541) 946-1309

Date: 7/1/25

Operator Certification #: N/A

OR

Small Groundwater System ☒