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

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

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

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 Crume Title: _____

Signature: Margaret Crume Phone #: (541) 946-1309

Date: 9/12/25

Operator Certification #: N/A

OR

Small Groundwater System ☒