

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

System Name **Rogue River Mobile Estates**

PWS ID# **41 01067**

Month/Year **3 121**

Entry Point: **WTP-A**

Required Minimum Residual **mg/L 0.2**

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	700		0.40	
2	730		0.40	70/6
3	630		0.40	
4	700		0.40	
5	610		0.40	
6	645		0.40	
7	730		0.40	
8	800		0.40	
9	610		0.40	
10	630		0.40	70/3
11	700		0.40	
12	600		0.40	
13	630		0.40	
14	700		0.40	
15	730		0.40	
16	600		0.40	
17	645		0.40	
18	600		0.40	
19	630		0.40	
20	730		0.40	
21	615		0.40	
22	645		0.40	
23	700		0.40	
24	600		0.40	
25	700		0.40	
26	600		0.40	
27	630		0.40	
28	715		0.40	
29	610		0.40	
30	700		0.40	
31	730		0.40	

Was the chlorine residual ever less than the required minimum residual of 0.2 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.

<p>GWS Serving 3,300 or Fewer</p> <p>If yes, did you monitor every four hours until the residual returned to _____ mg/L as required? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Attach those results and submit them with this form.</p>	<p>GWS Serving More Than 3,300</p> <p>Did continuous monitoring equipment fail at any time this reporting month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, were grab samples collected every four hours until the continuous monitoring equipment was returned to service as required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Attach grab sample results and submit them with this form.</p>	<p>Date continuous monitoring equipment failed: _____</p> <p>Date it was returned to service: _____</p>
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Printed Name: **CAROL BOETTCHER** Title: **MGR** Operator Certification #: _____
 Signature: *Carol Boettcher* Phone #: **(41) 582-1247** OR
 Date: **4 11 121** Small Groundwater System

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