State of Oregon Drinking Water Program

Monthly Disinfection Report for Ground Water Systems

System Name: Alsea Hatchery PWS ID# 41 05063

Month/Year: 9/24 Entry Point: Feed Rooms #1 Required Minimum Residual: .3 mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	8am	Fed Rooms #1	.8	
2	8am	"	.8	
3	8am	"	.8	
4	8am	"	.8	
5	8am	"	.8	
6	8am	"	.8	
7	8am	"	.8	
8	8am	"	.8	
9	730am	"	.8	
10	8am	"	.8	
11	8am	"	.8	
12	8am	"	.8	
13	8am	"	.8	
14	8am	"	.8	
15	730am	"	.8	
16	730am	"	.8	
17	730am	"	.8	
18	8am	"	.8	
19	8am	"	.8	
20	8am	"	.8	
21	8am	"	.8	
22	8am	"	.8	
23	8am	"	.8	
24	8am	"	.8	
25	8am	"	.8	
26	8am	"	.8	
27	8am	"	.8	
28	8am	"	.8	
29	8am	"	.8	
30	8am	"	.8	
~~31~~				

Was the chlorine residual ever less than the required minimum residual of .3 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: William Frank Title: Mgr

Signature: [signature] Phone #: (541) 487 7240

Date: 9/30/24

Operator Certification #: _____

OR

Small Groundwater System ☐