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

System Name __Aisea Hatchery__   PWS ID# 41 __05063__

Month/Year __7 / 22__   Entry Point: __Feed Room Si'X__   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	730am	Feed Room Sink	.8	
2	8am	"	.8	
3	8am	"	.8	
4	8am	"	.8	
5	8am	"	.8	
6	8am	"	.8	
7	8am	"	.8	
8	8am	"	.6	
9	8am	"	.8	
10	8am	"	.8	
11	730am	"	.7	
12	730am	"	.7	
13	8am	"	.8	
14	8am	"	.8	
15	8am	"	.8	
16	8am	"	.8	
17	8am	"	.8	
18	8am	"	.7	
19	8am	"	.6	
20	8am	"	.6	
21	8am	"	.8	
22	8am	"	.8	
23	8am	"	.8	
24	8am	"	.6	
25	8am	"	.7	
26	8am	"	.7	
27	8am	"	.7	
28	8am	"	.8	
29	6am	"	.6	
30	7am	"	.7	
31	6am	"	.8	

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	GWS Serving More Than 3,300	
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.*	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: __mg__   Operator Certification #:_____

Signature: __allison__   Phone #: __(541) 4877240__   OR

Date: __7 / 31 / 22__   Small Groundwater System ☐

December 19, 2012