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

System Name: **Alsea Hatchery** PWS ID# **410506)**

Month/Year: **8/23** Entry Point: **Feed Room Sink** 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	.7	
2	8am	"	.7	
3	8am	"	.8	
4	8am	"	.8	
5	8am	"	.7	
6	8am	"	.7	
7	8am	"	.7	
8	8am	"	.3	
9	8am	"	.8	
10	730am	"	.7	
11	8am	"	.8	
12	730am	"	.8	
13	8am	"	.8	
14	8am	"	.8	
15	8am	"	.7	
16	8am	"	.7	
17	8am	"	.8	
18	730am	"	.8	
19	730am	"	.8	
20	8am	"	.8	
21	8am	"	.8	
22	8am	"	.7	
23	8am	"	.7	
24	8am	"	.8	
25	730am	"	.8	
26	8am	"	.8	
27	8am	"	.8	
28	8am	"	.8	
29	8am	"	.8	
30	8am	"	.8	
31	8am	"	.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 M. Frank** Title: **Mgr**

Signature: **aourum** Phone #: **(541) 487-7240**

Date: **9/1/23**

Operator Certification #: **410506)**

OR

Small Groundwater System ☐

December 19, 2012