

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

System Name Alicea Hatchery PWS ID# 4105063
 Month/Year 11 / 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	8am	Feed Room Sink	3	
2	8am	"	3	
3	8am	"	3	
4	8am	"	3	
5	8am	"	3	
6	8am	"	3	
7	8am	"	3	
8	8am	"	3	
9	8am	"	3	
10	8am	"	3	
11	8am	"	3	
12	8am	"	3	
13	8am	"	3	
14	8am	"	3	
15	8am	"	3	
16	8am	"	3	
17	8am	"	3	
18	7:24am	"	3	
19	7:24am	"	3	
20	8am	"	3	
21	8am	"	3	
22	8am	"	3	
23	8am	"	3	
24	"	"	3	
25	"	"	3	
26	"	"	3	
27	"	"	3	
28	7:30am	"	3	
29	8am	"	3	
30	8am	"	3	
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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.

<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 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: William M. Frank Title: MG Operator Certification # 4105063
 Signature: [Signature] Phone #: (541) 487-7240 OR
 Date: 12/13/23 Small Groundwater System