

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

System Name Alicea Hatchery PWS ID# 4105063
 Month/Year 2/24 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	1.8	
2	8am	"	1.3	
3	8am	"	1.2	
4	8am	"	1.2	
5	8am	"	1.2	
6	8am	"	1.2	
7	8am	"	1.2	
8	8am	"	1.2	
9	8am	"	1.2	
10	8am	"	1.2	
11	8am	"	1.2	
12	8am	"	1.2	
13	8am	"	1.2	
14	8am	"	1.2	
15	8am	"	1.2	
16	8am	"	1.2	
17	8am	"	1.2	
18	8am	"	1.2	
19	8am	"	1.2	
20	8am	"	1.2	
21	8am	"	1.2	
22	8am	"	1.2	
23	8am	"	1.2	
24	8am	"	1.2	
25	8am	"	1.2	
26	8am	"	1.2	
27	8am	"	1.2	
28	8am	"	1.2	
29	7:30am	"	1.2	
30				
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.

<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: Mgr Operator Certification # 4105063
 Signature: [Signature] Phone #: (541) 457-7240
 Date: 2/29/24 OR
 Small Groundwater System