

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

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

GWS Serving 3,300 or Fewer 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 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? <input type="checkbox"/> Yes <input type="checkbox"/> No 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 Attach grab sample results and submit them with this form.		Date continuous monitoring equipment failed: _____/_____/_____ Date it was returned to service: _____/_____/_____
Printed Name: <u>William M. Frank</u> Signature: <u>[Signature]</u> Date: <u>2/28/21</u>		Title: <u>Mgr</u> Phone #: <u>(541) 457-7240</u>		Operator Certification # <u>4105063</u> OR Small Groundwater System <input type="checkbox"/>