

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

System Name: Alicea Hatchery PWS ID# 4105063  
 Month/Year: 4/25 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	"	8	
3	8am	"	8	
4	8am	"	8	
5	8am	"	8	
6	8am	"	8	
7	8am	"	8	
8	8am	"	8	
9	730am	"	8	
10	8am	"	8	
11	8am	"	8	
12	8am	"	8	
13	8am	"	8	
14	8am	"	8	
15	8am	"	8	
16	8am	"	8	
17	8am	"	8	
18	8am	"	8	
19	8am	"	8	
20	730am	"	8	
21	8am	"	8	
22	8am	"	8	
23	8am	"	8	
24	8am	"	8	
25	8am	"	8	
26	8am	"	8	
27	8am	"	8	
28	8am	"	8	
29	8am	"	8	
30	8am	"	8	
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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.

<b>GWS Serving 3,300 or Fewer</b> 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.	<b>GWS Serving More Than 3,300</b> 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: _____/_____/_____
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Printed Name: William M. Frank Title: Mgr Operator Certification # 4105063  
 Signature: [Signature] Phone #: (541) 457-7240  
 Date: 4/30/25 OR  
 Small Groundwater System ☐