

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

System Name Cold Springs PWS ID# 41 05201  
 Month/Year 6.124 Entry Point: Required Minimum Residual  mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	4p		1.00	
2	4p		.90	
3	4p		.90	
4	3p		.85	
5	4p		.90	
6	4p		.90	
7	3p		1.00	
8	4p		1.10	
9	4p		1.10	
10	3p		1.10	
11	4p		.90	
12	4p		.80	
13	4p		.80	
14	4p		1.20	
15	3p		1.20	
16	2p		1.10	
17	4p		1.00	
18	4p		.95	
19	4p		.90	
20	4p		.90	
21	4p		1.30	
22	4p		1.15	
23	4p		1.10	
24	3p		.90	
25	4p		.80	
26	4p		2.67	
27	4p		2.80	
28	4p		2.80	
29	4p		2.50	
30	4p		2.33	
31	4p		2.21	

Was the chlorine residual ever less than the required minimum residual of .70 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><b>GWS Serving 3,300 or Fewer</b></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><i>Attach those results and submit them with this form.</i></p>	<p><b>GWS Serving More Than 3,300</b></p> <p>Did continuous monitoring equipment fail at any time this reporting month? <input type="checkbox"/> Yes <input checked="" 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><i>Attach grab sample results and submit them with this form.</i></p>	<p>Date continuous monitoring equipment failed: / /</p> <p>Date it was returned to service: / /</p>
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Printed Name: Lisa Criss Title: Account Clerk Operator Certification #: \_\_\_\_\_  
 Signature: [Signature] Phone #: (503) 985-7541 OR  
 Date: 7/8/24 Small Groundwater System