

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

System Name Cold Springs PWS ID# 41-05201
 Month/Year 8/24 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	11		2.25	
2	11		2.30	
3	11		2.20	
4	11		2.15	
5	11		1.45	
6	11		1.30	
7	11		1.26	
8	11		1.60	
9	11		1.55	
10	11		1.45	
11	11		1.40	
12	11		1.20	
13	11		1.35	
14	11		1.25	
15	11		1.29	
16	11		1.45	
17	11		1.45	
18	11		1.50	
19	11		1.60	
20	11		2.16	
21	11		1.73	
22	11		1.64	
23	11		1.69	
24	11		1.50	
25	11		1.45	
26	11		1.16	
27	11		1.32	
28	11		1.29	
29	11		1.36	
30	11		1.31	
31	11		1.28	

Was the chlorine residual ever less than the required minimum residual of _____ 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 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>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: Lisa Griss Title: Accounts Clerk Operator Certification #: _____
 Signature: [Signature] Phone #: (503) 985-7561 OR
 Date: 9/15/24 Small Groundwater System