

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

System Name Cold Springs 4105201 PWS ID# 41  
 Month/Year 09 12022 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	2		1.07	
2	2		1.02	
3	2		1.0	
4	2		1.98	
5	2		1.0	
6	2		1.96	
7	2		1.96	
8	2		1.92	
9	2		1.88	
10	2		1.87	
11	2		1.88	
12	2		1.84	
13	2		1.85	
14	2		1.87	
15	2		1.81	
16	2		1.83	
17	2		1.84	
18	2		1.85	
19	2		1.81	
20	2		1.79	
21	2		1.78	
22	2		1.79	
23	2		1.76	
24	2		1.81	
25	2		1.86	
26	2		1.89	
27	2		1.88	
28	2		1.87	
29	2		1.85	
30	2		1.84	
31				

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><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>Attach those results and submit them with this form.</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>Attach grab sample results and submit them with this form.</p>	<p>Date continuous monitoring equipment failed: _____ / _____ / <u>NA</u></p> <p>Date it was returned to service: _____ / _____ / <u>NA</u></p>
--	---	---

Printed Name: Roberto Teller Title: \_\_\_\_\_ Operator Certification #: \_\_\_\_\_  
 Signature: Roberto Teller Phone #: ( 971 ) 201-0662 OR  
 Date: 10 / 10 / 22 Small Groundwater System