

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

System Name Cold Springs 4105201 PWS ID# 41
 Month/Year 6/23 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				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27	<u>9</u>		<u>0.78</u>	
28	<u>9</u>		<u>0.76</u>	
29	<u>9</u>		<u>0.77</u>	
30	<u>9</u>		<u>0.79</u>	
31				

Was the chlorine residual ever less than the required minimum residual of 0.7 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><i>Attach those results and submit them with this form.</i></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><i>Attach grab sample results and submit them with this form.</i></p>	<p>Date continuous monitoring equipment failed: _____ / _____ / <u>N/A</u></p> <p>Date it was returned to service: _____ / _____ / <u>N/A</u></p>
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Printed Name: Jackson Harbolt Title: _____ Operator Certification #: _____
 Signature: Jackson P. Harbolt Phone #: (503) 985-7561 OR
 Date: 7/06/2023 Small Groundwater System