

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

System Name **Siuslaw Marina**

PWS ID# **41 05289**

Month/Year **10 / 2021** Entry Point: **EP-A**

Required Minimum Residual **0.4 mg/L**

Date	Time P.M.	Source(s) in use KITCHEN TAP	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	9:24	"	0.7	
2	9:18	"	0.8	
3	9:20	"	0.7	
4	9:10	"	0.5	
5	9:35	"	0.4	
6	9:15	"	0.4	
7	9:13	"	0.4	
8	7:56	"	0.4	
9	9:23	"	0.5	
10	9:28	"	0.5	
11	7:07	"	0.5	
12	9:05	"	0.5	
13	9:34	"	0.6	
14	9:30	"	0.5	
15	8:54	"	0.5	
16	10:16	"	0.5	
17	9:12	"	0.5	
18	9:14	"	0.5	
19	7:01	"	0.6	
20	7:43	"	0.6	
21	8:15	"	0.7	
22	7:25	"	0.7	
23	8:45	"	0.8	
24	9:14	"	0.8	
25	8:30	"	0.8	
26	9:04	"	0.8	
27	9:20	"	0.8	
28	9:25	"	0.7	
29	8:55	"	0.7	
30	8:43	"	0.7	
31	9:10	"	0.7	

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 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: Kirby Hansen Title: OWNER Operator Certification #: _____
 Signature: Kirby Hansen Phone #: (541) 997-3254 OR
 Date: 11/9/2021 Small Groundwater System