

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

System Name Eastgate Vet Clinic PWS ID# 41
 Month/Year 1/1/2024 Entry Point: Required Minimum Residual 0.8 mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1		<u>Client Bathroom</u>		
2	<u>5pm</u>		<u>1.0</u>	<u>0144108</u>
3				
4	<u>5pm</u>		<u>1.0</u>	
5				
6				
7				
8	<u>6pm</u>		<u>1.4</u>	<u>014479</u>
9	<u>5pm</u>		<u>1.0</u>	
10	<u>5pm</u>		<u>1.0</u>	
11	<u>6:30pm</u>		<u>1.4</u>	
12				
13				
14				
15	<u>5pm</u>		<u>1.4</u>	<u>014507</u> tank refilled
16	<u>6pm</u>		<u>1.4</u>	
17	<u>6pm</u>		<u>1.4</u>	
18	<u>5:30pm</u>		<u>1.0</u>	6 cups of 10 gal water
19				
20				
21				
22	<u>5pm</u>		<u>1.4</u>	<u>014527</u>
23	<u>6p</u>		<u>1.4</u>	<u>014530</u>
24				
25	<u>6:30p</u>		<u>1.4</u>	<u>014539</u>
26				
27				
28	<u>5pm</u>		<u>1.4</u>	<u>014551</u>
29	<u>6pm</u>		<u>1.0</u>	
30	<u>6pm</u>		<u>1.4</u>	
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>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>	

Printed Name: Kathlyn Callaway Title: practice manager Operator Certification #: _____
 Signature: [Signature] Phone #: (541) 752-3786 OR
 Date: 4/15/24 Small Groundwater System

Return by 10th of following month by either email dwp.dmce@state.or.us; fax 971-673-0694; or mail to Drinking Water Services, PO Box 14350, Portland, OR 97293-0350.