

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

RECEIVED

MAY 04 2023

Certification
Drinking Water Services

System Name **Westridge Subdivision**

PWS ID# **4 1 05998**

Month/Year **4 / 23** Entry Point: **EP-A (EP for Well)**

Required Minimum Residual **0.4 mg/L**

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	8:30	Westridge Well	.7	
2	10:00		.6	
3	8:00		.6	
4	8:00		.5	
5	8:30		.6	
6	8:00		.7	
7	8:00		.7	
8	9:00		.8	
9	10:15		.8	
10	8:30		.7	
11	8:30		.6	
12	8:00		.6	
13	8:00		.7	
14	8:00		.8	
15	8:30		.8	
16	10:00		.7	
17	9:00		.7	
18	8:30		.6	
19	9:00		.6	
20	10:00		.5	
21	8:00		.6	
22	8:00		.7	
23	10:30		.6	
24	9:00		.6	
25	9:30		.5	
26	10:00		.6	
27	9:00		.7	
28	8:30		.7	
29	8:00		.6	
30	10:00		.6	
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>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Date continuous monitoring equipment failed: / /

Date it was returned to service: / /

Printed Name: **Wayne Logney** Title: **Water Officer** Operator Certification #: _____
 Signature: *Wayne Logney* Phone #: **(541) 815-4478** OR
 Date: **5 / 2 / 23** Small Groundwater System

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