

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

System Name Kellogg Springs Camp Christian Camp

PWS ID# 4 1 90490

Month/Year 6/2021

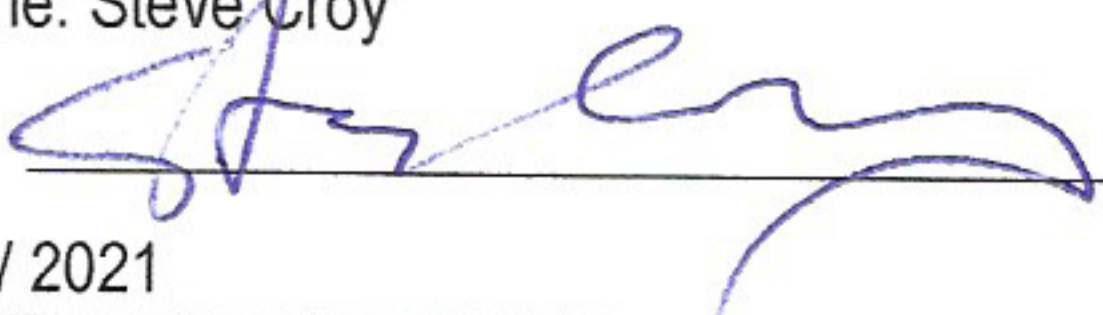
Entry Point: First User ( Shop)

Required Minimum Residual .04 mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	8.59	AA,AB,AC,AF	.6	
2	9.00	AA,AB,AC,AF	.6	
3	8.27	AA,AB,AC,AF	.7	
4	8.51	AA,AB,AC,AF	.7	
5	7.34	AA,AB,AC,AF	.7	
6	11.29	AA,AB,AC,AF	.6	
7	9.02	AA,AB,AC,AF	.6	
8	12.11	AA,AB,AC,AF	.5	
9	8.32	AA,AB,AC,AF	.4	
10	8.54	AA,AB,AC,AF	.6	
11	9.31	AA,AB,AC,AF	.5	
12	8.39	AA,AB,AC,AF	.6	
13	9.03	AA,AB,AC,AF	.6	
14	9.09	AA,AB,AC,AF	.6	
15	9.23	AA,AB,AC,AF	.6	
16	9.35	AA,AB,AC,AF	.4	
17	8.05	AA,AB,AC,AF	.5	
18	8.35	AA,AB,AC,AF	.6	
19	7.56	AA,AB,AC,AF	.4	
20	8.20	AA,AB,AC,AF	.7	
21	8.05	AA,AB,AC,AF	.4	
22	8.20	AA,AB,AC,AF	.5	
23	6.41	AA,AB,AC,AF	.4	
24	7.32	AA,AB,AC,AF	.7	
25	6.56	AA,AB,AC,AF	.4	
26	7.46	AA,AB,AC,AF	.4	
27	9.54	AA,AB,AC,AF	.7	
28	7.22	AA,AB,AC,AF	.8	
29	7.31	AA,AB,AC,AF	.7	
30	6.52	AA,AB,AC,AF	.7	
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Was the chlorine residual ever less than the required minimum residual of .4 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><i>Attach those results and submit them with this form.</i></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 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: _____ / _____ / _____</p> <p>Date it was returned to service: _____ / _____ / _____</p>
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Printed Name: Steve Croy Signature:  Date: 7 / 1 / 2021	Title: Facilities Director Phone #: (541) 459-1511ext462	Operator Certification #: OR Small Groundwater System <input checked="" type="checkbox"/>
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