

**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 3/2023


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	0944	AA,AB,AC,AF	.5	
2	0953	AA,AB,AC,AF	.5	
3	0850	AA,AB,AC,AF	.5	
4	1118	AA,AB,AC,AF	.5	
5	0136	AA,AB,AC,AF	.5	
6	1007	AA,AB,AC,AF	.5	
7	1021	AA,AB,AC,AF	.5	
8	0900	AA,AB,AC,AF	.6	
9	0923	AA,AB,AC,AF	.6	
10	0983	AA,AB,AC,AF	.6	
11	0734	AA,AB,AC,AF	.6	
12	0754	AA,AB,AC,AF	.6	
13	0926	AA,AB,AC,AF	.6	
14	0842	AA,AB,AC,AF	.6	
15	0947	AA,AB,AC,AF	.6	
16	0951	AA,AB,AC,AF	.6	
17	1007	AA,AB,AC,AF	.6	
18	0725	AA,AB,AC,AF	.6	
19	1049	AA,AB,AC,AF	.6	
20	1114	AA,AB,AC,AF	1.0	
21	1523	AA,AB,AC,AF	1.0	
22	1029	AA,AB,AC,AF	.9	
23	1035	AA,AB,AC,AF	.9	
24	1044	AA,AB,AC,AF	1.5	
25	1057	AA,AB,AC,AF	1.5	
26	1316	AA,AB,AC,AF	1.0	
27	1013	AA,AB,AC,AF	.7	
28	0846	AA,AB,AC,AF	.5	
29	0802	AA,AB,AC,AF	.4	
30	0855	AA,AB,AC,AF	.4	
31	0735	AA,AB,AC,AF	.4	

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.

GWS Serving 3,300 or Fewer	GWS Serving More Than 3,300	
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 <i>Attach those results and submit them with this form.</i>	Did continuous monitoring equipment fail at any time this reporting month? <input type="checkbox"/> Yes <input type="checkbox"/> No 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 <i>Attach grab sample results and submit them with this form.</i>	Date continuous monitoring equipment failed: _____ / _____ / _____ Date it was returned to service: _____ / _____ / _____

Printed Name: Steve Croy Signature:  Date: 4 / 2 / 2023	Title: Facilities Director Phone #: (541) 459-1511ext462	Operator Certification #: OR Small Groundwater System <input checked="" type="checkbox"/>
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