

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

System Name Triangle Lake Charter School PWS ID# 41 90556  
 Month/Year May 21 Entry Point: South Kite Sink Required Minimum Residual 0.2 mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1				
2		NO School		
3	9:00			
4	9:30		.62	
5	10:00		.65	
6	9:00		.63	
7			.66	
8		NO sch.		
9				
10	9:00		.59	
11	1:00		.67	
12	8:30		.61	
13	11:00		.68	
14				
15		NO Sch.		
16				
17	9:00		.63	
18	9:30		.67	
19	10:00		.65	
20	9:30		.70	
21				
22		NO Sch.		
23				
24	10:00		.65	
25	9:00		.70	
26	11:00		.75	
27	9:00		.80	
28				
29		NO School		
30				
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><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>Attach those results and submit them with this form.</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>Attach grab sample results and submit them with this form.</p>
	<p>Date continuous monitoring equipment failed: _____/_____/_____                  Date it was returned to service: _____/_____/_____</p>

Printed Name: Jeff Richardson Title: Transportation Operator Certification #: \_\_\_\_\_  
 Signature: [Signature] Phone #: (541) 925-3262 OR  
 Date: 6-7-21 E: 124 Small Groundwater System