

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

System Name **Rogue River Campground**

PWS ID# **4 1 91541**


Month/Year **Nov /2024** Entry Point: **A**

Required Minimum Residual **0.30 mg/L**

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1				
2				
3				
4			0.5	
5			0.5	
6				
7			0.5	
8				
9				
10				
11				
12				
13			0.5	
14			0.5	
15			0.5	
16				
17				
18			0.5	
19			0.5	
20				
21			0.5	
22				
23				
24				
25			0.5	Added Cl- to tank
26			0.5	
27			0.5	
28				
29				
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>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><i>Attach those results and submit them with this form.</i></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><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: _____	Title: _____	Operator Certification #: _____
Signature: 	Phone #: () _____	OR
Date: 12/10/24		Small Groundwater System <input type="checkbox"/>

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.