

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

System Name **Rogue River Campground**

PWS ID# **41 91541**

Month/Year **April** /2025

Entry Point: **A**

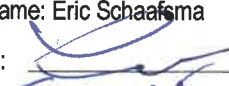
Required Minimum Residual **0.30 mg/L**

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	9:00	Well-GW	0.5	
2	9:00	Well-GW	0.5	
3	9:00	Well-GW	0.5	
4	9:00	Well-GW	0.5	
5	9:00	Well-GW	0.5	
6	9:00	Well-GW	0.5	
7	9:00	Well-GW	0.5	
8	9:00	Well-GW	0.5	
9	9:00	Well-GW	0.5	
10	9:00	Well-GW	0.5	
11	9:00	Well-GW	0.5	filled CT dose tank
12	9:00	Well-GW	0.5	
13	9:00	Well-GW	0.5	
14	9:00	Well-GW	0.5	
15	9:00	Well-GW	0.5	
16	9:00	Well-GW	0.5	
17	9:00	Well-GW	0.5	
18	9:00	Well-GW	0.5	
19	9:00	Well-GW	0.5	
20	9:00	Well-GW	0.5	
21	9:00	Well-GW	0.5	
22	9:00	Well-GW	0.5	
23	9:00	Well-GW	0.5	
24	9:00	Well-GW	0.5	
25	9:00	Well-GW	0.5	
26	9:00	Well-GW	0.5	
27	9:00	Well-GW	0.5	
28	9:00	Well-GW	0.5	
29	9:00	Well-GW	0.5	
30	9:00	Well-GW	0.5	
31	9:00	Well-GW	0.5	

Was the chlorine residual ever less than the required minimum residual of 0.30 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 align="center"><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>

Printed Name: <b>Eric Schaafsma</b>	Title: <b>Operator</b>	Operator Certification #: <b>D-09353</b>
Signature: 	Phone #: <b>(541)659-0700</b>	OR
Date: <b>5/8/25</b>		Small Groundwater System <input type="checkbox"/>

**Return by 10<sup>th</sup> of following month by either email [dwp.dmce@dhsosha.state.or.us](mailto:dwp.dmce@dhsosha.state.or.us); fax 971-673-0694; or mail to Drinking Water Services, PO Box 14350, Portland, OR 97293-0350.**