

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

System Name Elk Lake Resort PWS ID# 41 91734  
 Month/Year 02/21 Entry Point: Treatalike Required Minimum Residual 0.4 mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1		Well	Closed	
2			Closed	
3			Closed	
4			.52	
5			.49	
6			.50	
7			.51	
8			Closed	
9			Closed	
10			Closed	
11			.49	
12			.46	
13			.48	
14			.47	
15			.46	
16			Closed	
17			Closed	
18			.47	
19			.49	
20			.46	
21			.45	
22			Closed	
23			Closed	
24			Closed	
25			.49	
26			.49	
27			.50	
28			.51	
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><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: ___/___/___</p> <p>Date it was returned to service: ___/___/___</p>
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Printed Name: PAT FRIEVE Title: Owner Operator Certification #: \_\_\_\_\_  
 Signature: [Signature] Phone #: ( ) \_\_\_\_\_ OR  
 Date: 02/10/21 503 501 9795 Small Groundwater System