State of Oregon Drinking Water Program

# Monthly Disinfection Report for Ground Water Systems

System Name Elk Lake Resort PWS ID# 41 00737

Month/Year 04/22 Entry Point: Treated Sk Required Residual 0.4 mg/L

| Date | Time | Source(s) in use | Lowest free chlorine residual at entry point to distribution system | Notes |
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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.

**GWS Serving 3,300 or Fewer**

If yes, did you monitor every four hours until the residual returned to _____ mg/L as required? ☐ Yes ☐ No

Attach those results and submit them with this form.

**GWS Serving More Than 3,300**

Did continuous monitoring equipment fail at any time in the reporting month? ☐ Yes ☐ No

If yes, were grab samples collected every four hours until the continuous monitoring equipment was returned to service as required? ☐ Yes ☐ No

Attach grab sample results and submit them with this form.

Date continuous monitoring equipment failed: ___/___/___

Date it was returned to service: ___/___/___

Printed Name: _____ Title: _____

Signature: _____ Phone #: (___) _____

Date: ___/___/___

Operator Certification #: _____

OR

Small Groundwater System ☐