

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

System Name Elk Lake Resort PWS ID# 41 90737
 Month/Year 12/22 Entry Point: Treated Site Required Residual 0.4 mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system <input checked="" type="checkbox"/>	Notes
1		Well	.54	
2			.56	
3			.56	
4			.53	
5			closed	
6			closed	
7			closed	
8			.58	
9			.57	
10			.53	
11			.56	
12			closed	
13			closed	
14			closed	
15			closed	
16			closed .54	
17			.55	
18			.52	
19			.49	
20			.53	
21			.52	
22			.51	
23			.48	
24			.49	
25			.46	
26			.47	
27			.44	
28			.45	
29			.49	
30			.45	
31			.47	

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 to be notified by end of next business day.

<p>GWS Serving 3,300 or Fewer</p> <p>If yes, did you monitor every <u>15</u> minutes 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>GWS Serving More Than 3,300</p> <p>Did continuous monitoring equipment fail at any time <input checked="" type="checkbox"/> reporting month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date continuous monitoring equipment failed: _____ / _____ / _____</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>Date it was returned to service: _____ / _____ / _____</p> <p>Attach grab sample results and submit them with this form.</p>
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Printed Name: Pat Prave Title: Owner Operator Certification #: _____
 Signature: [Signature] Phone #: (____) 503 501 8782
 Date: 01/10/23

OR
Small Groundwater System