

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

System Name Elk Lake Resort PWS ID# 41 91737  
 Month/Year 01/23 Entry Point: Trusted 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	0.58	
2			Closed	
3			Closed	
4			Closed	
5			0.62	
6			0.59	
7			0.60	
8			0.58	
9			Closed	
10			Closed	
11			Closed	
12			0.61	
13			0.59	
14			0.58	
15			0.55	
16			0.56	
17			Closed	
18			Closed	
19			0.63	
20			0.61	
21			0.61	
22			0.57	
23			Closed	
24			Closed	
25			Closed	
26			0.64	
27			0.65	
28			0.63	
29			0.59	
30			Closed	
31			Closed	

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><b>GWS Serving 3,300 or Fewer</b></p> <p>If yes, did you monitor every <u>hour</u> 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 align="center"><b>GWS Serving More Than 3,300</b></p> <p>Did continuous monitoring equipment fail at any time in 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: [Signature] Title: Anal Operator Certification #: \_\_\_\_\_  
 Signature: [Signature] Phone #: ( ) \_\_\_\_\_ OR  
 Date: 02/09/23 503.501.8785 Small Groundwater System