

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

System Name Elk Lake Resort PWS ID# 41 91237
 Month/Year 02/23 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 ↕	closed	
2			.50	
3			.48	
4			.49	
5			.46	
6			closed	
7			closed	
8			closed	
9			.51	
10			.49	
11			.46	
12			.47	
13			closed	
14			closed	
15			closed	
16			.53	
17			.53	
18			.49	
19			.47	
20			.45	
21			closed	
22			closed	
23			.46	
24			.44	
25			.40	
26			.41	
27			closed	
28			closed	
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 to be notified by end of next business day.

<p>GWS Serving 3,300 or Fewer</p> <p>If yes, did you monitor every <input checked="" type="checkbox"/> 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">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>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: _____/_____/_____ Date it was returned to service: _____/_____/_____</p>
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Printed Name: Pat Brive Title: Operator Operator Certification #: _____
 Signature: [Signature] Phone #: () _____ OR
 Date: 03/09/23 503.501.8785 Small Groundwater System