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

System Name: _Riverpark RV Resort_   PWS ID# _419/911_

Month/Year _1_ / _22_   Entry Point: _Office_   Required Minimum Residual _1.0_ mg/L.

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	10:00		1.12	
2			.47	
3			.41	
4			.41	
5			.40	
6			.39	
7			.40	
8			.39	
9			.41	
10			1.40	
11			.40	
12			.39	
13			1.39	
14			1.40	
15			.38	
16			.40	
17			.4	
18			.40	
19			.39	
20			1.39	
21			.38	
22			.39	
23			.39	
24			.38	
25			.39	
26			.39	
27			.37	
28			.38	
29			.38	
30			.37	
31			.37	

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

GWS Serving 3,300 or Fewer	GWS Serving More Than 3,300	
If yes, did you monitor every four hours until the residual returned to _____ mg/L? Attach those results and submit them with this form.	Did continuous monitoring equipment fail at any time this reporting month? ☐ Yes ☐ No If yes, were grab samples collected every four hours until the continuous monitoring equipment was returned to service? ☐ 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: _Donna Logan_   Title: _Owner_   _541-295-1269_   Operator Certification #: _____

Signature: _Donna Logan_