

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

System Name Riverpark RV Resort PWS ID# 41 91911  
 Month/Year 9 12 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		1.27	
2	10:00		1.26	
3	10:00		1.25	
4	10:00		1.26	
5	10:00		1.26	
6	10:00		1.25	
7	10		1.24	
8	10		1.25	
9	10		1.25	
10	10		1.24	
11	10		1.24	
12	10		1.22	
13	10		1.22	
14	10		1.22	
15	10		1.22	
16	10		1.22	
17	10		1.20	
18	10		1.41	
19	10		1.41	
20	10		1.39	
21	10		1.40	
22	10		1.40	
23	10		1.39	
24	10		1.39	
25	10		1.38	
26	10		1.38	
27	10		1.36	
28	10		1.37	
29	10		1.38	
30	10		1.38	
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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 - 0  > 4 hours. Drinking Water Program to be notified by end of next business day.

<p>Leads serving 3,000 or fewer</p> <p>If yes, did you monitor every four hours until the residual returned to _____ mg/L as required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Attach more details and submit them with this form.</p>	<p>Leads serving more than 3,000</p> <p>Do continuous monitoring equipment test at any time this reporting month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, were you notified within 15 minutes of any test failure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Attach test results and submit them with this form.</p>
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Printed Name: Donna Logan Title: \_\_\_\_\_ Operator Certification #: \_\_\_\_\_  
 Signature: [Signature] Phone #: 541-295-1269  
 Date: \_\_\_\_\_ Small Groundwater System