

Monthly Disinfection Report for Ground Water Systems

System Name **Smith River Marina**

PWS ID# **41 92133**

Month/Year **08 12023** Entry Point **Post Reservoir /to RV**

Required Minimum Residual **0.5 mg/L**

Date	Time AM	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	6:50	Club House	0.8	OK
2	6:20	"	1.2	
3	6:00	"	0.6	
4	6:30	PUMP House	0.4	
5	6:30	"	0.8	
6	6:20	"	1.0	
7	6:10	"	1.3	
8	6:05	"	0.8	
9	7:30	"	0.6	
10	6:20	SPACE 14	0.7	
11	6:10	PUMP House	0.6	
12	6:30	"	0.8	
13	6:20	"	0.7	
14	6:30	"	0.6	
15	6:00	"	0.7	Adjust chlorinator
16	7:20	PUMP House	1.0	
17	6:20	Club House	1.2	
18	6:30	Club House	0.9	
19	7:10	PUMP House	0.8	
20	7:20	SPACE 14	0.6	
21	8:30	PUMP House	0.5	
22	9:10	"	0.7	
23	6:20	"	0.8	
24	6:20	"	1.0	
25	7:20	"	0.9	
26	6:20	"	1.2	
27	7:00	Club House	1.0	
28	6:30	PUMP House	0.8	
29	6:20	"	0.6	
30	7:00	"	0.7	
31	8:00	"	0.8	

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 Program to be notified by end of next business day.

GWS Serving 3,300 or Fewer
 If yes, did you monitor every four hours until the residual returned to _____ mg/L as required? Yes No
 Attach those results and submit them with this form.

GWS Serving More Than 3,300
 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 as required? 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: **LEE, FANG CITUNG** Title: **OWNER**
 Signature: *[Signature]* Phone #: **(541) 707 0914**
 Date: **09/05/2023**

Operator Certification #: _____
 OR
 Small Groundwater System