

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

System Name **LOST VALLEY CENTER** PWS ID# 41 **94011**  
 Month/Year **10/23** Entry Point: **A** Required Minimum Residual **.2** mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1	9 AM	BARW SINK	.4	SB
2	9 AM	BARW SINK	.4	SB
3	9 AM	" "	.4	SB
4	7 AM	" "	.4	SB
5	7 AM	" "	.4	SB
6	6 AM	" "	.4	SB
7	9 AM	" "	.4	SB
8	10 AM	" "	.4	SB
9	10 AM	" "	.4	SB
10	9 AM	" "	.4	SB
11	9 AM	" "	.4	SB
12	7 AM	" "	.4	SB
13	7 AM	" "	.4	SB
14	7 AM	" "	.4	SB
15	6 AM	" "	.4	SB
16	7 AM	" "	.4	SB
17	7 AM	" "	.4	SB
18	8 AM	" "	.4	SB
19	7 AM	" "	.4	SB
20	7 AM	" "	.4	SB
21	9 AM	" "	.4	SB
22	7 AM	" "	.4	SB
23	11 AM	" "	.4	SB
24	11 AM	" "	.4	SB
25	9 AM	" "	.4	SB
26	9 AM	" "	.4	SB
27	7 AM	" "	.4	SB
28	7 AM	" "	.4	SB
29	8 AM	" "	.4	SB
30	9 AM	" "	.4	SB
31	9 AM	" "	.4	SB

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.

<p><b>GWS Serving 3,300 or Fewer</b>                  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                  Attach those results and submit them with this form.</p>	<p><b>GWS Serving More Than 3,300</b>                  Did continuous monitoring equipment fail at any time this reporting month? <input type="checkbox"/> Yes <input type="checkbox"/> No                  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                  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: **SAM BASCOM** Title: **MAINT. ASST.** Operator Certification #: \_\_\_\_\_  
 Signature: *Sam Bascom* Phone #: ( ) \_\_\_\_\_ OR \_\_\_\_\_  
 Date: **10/31/2023** **541-525-3095** Small Groundwater System

Return by 10<sup>th</sup> of following month by either email [dwp.dmce@state.or.us](mailto:dwp.dmce@state.or.us); fax 971-673-0694; or mail to Drinking Water Services, PO Box 14350, Portland, OR 97293-0350.