

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

System Name LOST VALLEY CENTER PWS ID# 41 94011  
 Month/Year 12 2025 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	4:00	Building 15	.3	SLF Salt 1/2 bag
2	4:30	"	.3	SLF 1/2 bag
3	2:00	" "	.3	SLF 1/2 bag
4	4:15	" "	.3	SLF 1/2 bag
5	2:30	" "	.3	SLF 1/2 bag
6	3:45	" "	.4	SLF 1/2 bag
7	2:45	" "	.4	SLF 1/2 bag
8	3:30	" "	.4	SLF
9	3:15	" "	.5	SLF
10	12:30	" "	.4	SLF 1/2 bag
11	4:00	" "	.4	SLF 1/2 bag
12	2:40	" "	.4	SLF
13	3:15	" "	.4	SLF 1 bag
14	3:15	" "	.4	SLF
15	3:30	" "	.4	SLF 1/2 bag
16	12:30	" "	.4	SLF 1/2 bag
17	2:45	" "	.4	SLF
18	2:00	" "	.4	SLF
19	4:30	" "	.3	SLF 1 bag
20	2:00	" "	.3	SLF 1/2 bag
21	2:30	" "	.4	SLF 1/2 bag
22	3:40	" "	.4	SLF
23	4:40	" "	.4	SLF 1/2 bag
24	4:00	" "	.4	SLF 1/2 bag
25	3:30	" "	.4	SLF
26	2:30	" "	.3	SLF 1 BAG
27	4:15	" "	.4	SLF
28	3:20	" "	.4	SLF 1/2 bag
29	4:00	" "	.4	SLF
30	3:15	" "	.4	SLF 1/2 bag
31	4:30	" "	.4	SLF

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></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 those results and submit them with this form.</p>	<p><b>GWS Serving More Than 3,300</b></p> <p>Did continuous monitoring equipment fail at any time this 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: _____ / _____ / _____</p> <p>Date it was returned to service: _____ / _____ / _____</p>

Printed Name: SHARON FRANTZ Title: monitor Operator Certification #: \_\_\_\_\_  
 Signature: Sharon Frantz Phone #: (503) 354 7591 OR  
 Date: 01/08/2026 Small Groundwater System

Return by 10<sup>th</sup> of following month by either email [dwp.dmce@odhsoha.oregon.gov](mailto:dwp.dmce@odhsoha.oregon.gov); fax 971-673-0458; or mail to Drinking Water Services, PO Box 14350, Portland, OR 97293-0350.