

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

System Name Rodeway Inn Rice Hill	PWS ID# 4 1 94803
Month/Year 10/01/21 Entry Point: Hose at Pool House	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	11.15am	AA	1.2	
2	11.35am	AA	1.2	
3	11.05	AA	1.2	
4	11.30am	AA	1.2	
5	11.45am	AA	1.2	
6	11.10am	AA	1.2	
7	11am	AA	1.2	
8	11am	AA	1.2	
9	10.40am	AA	1.2	
10	11am	AA	1.2	
11	11.20am	AA	1.2	
12	11am	AA	1.2	
13	11am	AA	1.2	
14	11am	AA	1.2	
15	11.10am	AA	1.2	
16	11.10am	AA	1.2	
17	11.30am	AA	1.2	
18	11.20am	AA	1.2	
19	11.15am	AA	1.2	
20	9am	AA	1.2	
21	10.45am	AA	1.2	
22	11.05am	AA	1.2	
23	9.45am	AA	1.2	
24	9.30am	AA	1.2	
25	10am	AA	1.2	
26	10am	AA	1.2	
27	10.20am	AA	1.2	
28	11am	AA	1.2	
29	10.25am	AA	1.2	
30	1.30pm	AA	1.2	
31		AA	1.2	

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>GWS Serving 3,300 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 checked="" type="checkbox"/> No</p> <p><i>Attach those results and submit them with this form.</i></p>	<p align="center">GWS Serving More Than 3,300</p> <table border="0" style="width:100%;"> <tr> <td style="width: 60%;"> Did continuous monitoring equipment fail at any time this reporting month? <input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> No <i>Attach grab sample results and submit them with this form.</i> </td> <td style="width: 40%;"> Date continuous monitoring equipment failed: _____ / _____ / _____ Date it was returned to service: _____ / _____ / _____ </td> </tr> </table>	Did continuous monitoring equipment fail at any time this reporting month? <input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> No <i>Attach grab sample results and submit them with this form.</i>	Date continuous monitoring equipment failed: _____ / _____ / _____ Date it was returned to service: _____ / _____ / _____
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Printed Name: TARLOCHAN SINGH	Title: GM	Operator Certification #:
Signature:	Phone #: (5418493335)	OR
Date: 10 / 31 / 21		Small Groundwater System <input checked="" type="checkbox"/>