State of Oregon Drinking Water Program

Monthly Disinfection Report for Ground Water Systems

System Name _____ PWS ID# 4 1 _____

Month/Year ____/____ Entry Point: _____ Required Minimum Residual ____ mg/L

Date	Time	Source(s) in use	Lowest free chlorine residual at entry point to distribution system (mg/L)	Notes
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
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28				
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30				
31				

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: _____ Title: _____

Signature: _____ Phone #: (____) _____

Date: ____/____ / ____

Operator Certification #:_____

OR

Small Groundwater System ☐