

SAFE DRINKING WATER PROGRAM

ENFORCEMENT UNIT - REPORT #2

MONTHLY CHLORINE RESIDUAL REPORT AT
ENTRY POINT OF MAXIMUM RESIDENCE TIME

MONTH _____ YEAR _____

PWS ID
SUPPLY NAME
CITY
PARISH
TELEPHONE
NAME OF CONTACT
TYPE OF CHLORINE USED
POINT OF MAXIMUM RESIDENCE TIME (SPECIFY)

ACTION TAKEN IF FREE CHLORINE RESIDUAL IS
LESS THAN 0.20 MILLIGRAMS PER LITER

DATE	TIME	ACTION TAKEN

CONTINUE ON OPPOSITE SIDE IF NEEDED

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE & CORRECT.

SIGNATURE OF RESPONSIBLE PARTY

DATE

DATE	TIME	CHLORINE RESIDUAL		INITIALS OF TESTER
		FREE	TOTAL	
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				

CHLORINE RESIDUAL RECORDED IN MILLIGRAMS PER LITER