_____ HEALTH DEPARTMENT

RECREATIONAL WATER FACILITY WEEKLY OPERATIONAL REPORT

FACILITY NAME: _____ DATES: _____

ADDRESS: (Street) _____ ☐ GAS CHLORINATOR ☐ SAND FILTRATION

(City) _____ ☐ HYPO CHLORINATOR ☐ D.E. FILTRATION

(County) _____ ☐ TABLET-ERROSION CHLORINATOR ☐ SODA ASH FEEDER

PHONE NUMBER: _____ LIFEGUARD REQUIRED Y / N

DAY	# of Bathers	# of Lifeguards Required	Filters Washed Y/N	Chlorinator Operated Y/N	Total Alkalinity	SWIMMING POOL												OTHER WATER FACILITIES Please specify_____ (ie Wading Pool, Lazy River, Water Slide)					
						SHALLOW						DEEP											
						AM		PM		EVE		AM		PM		EVE		AM		PM		EVE	
						pH	Cl_2	pH	Cl_2	pH	Cl_2	pH	Cl_2	pH	Cl_2	pH	Cl_2	pH	Cl_2	pH	Cl_2	pH	Cl_2
Sun.																							
Mon.																							
Tues.																							
Wed.																							
Thur.																							
Fri.																							
Sat.																							

REMARKS: _____

Copy must be maintained on site for review at the time of inspection.

MAIL TO: Local Health Department

Qualified Water Facility Operator _____

ER-32 2/2023