ER-32
Revised 4/2003

_____ DEPARTMENT OF HEALTH
RECREATIONAL WATER FACILITY
WEEKLY OPERATIONAL REPORT

FACILITY NAME:_____ WEEK ENDING: _____

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

(Town) _____ ☐ 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	Hours Chlorinator Operated	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: _____

_____

MAIL TO: Your Local Health Department Qualified Water Facility Operator _____