



## DENTAL FACILITY COMPLIANCE REPORT EPA 40 CFR 441

### SECTION A – FACILITY INFORMATION

Name of Dental Practice:		
Phone Number:	E-mail:	
Site Address:		
Mailing Address (if different from site address):		
Primary Contact for Amalgam Waste Issues	Total number of chairs:	
Name:		
Title:	Total number of chairs at which amalgam placement or removal occurs:	
Comments:		

**Please Select One of the Following**

<input type="checkbox"/>	This practice is a dental discharger subject to this rule as it places or removes dental amalgam. <b>Complete Sections A, B, C, D, and E</b>
<input type="checkbox"/>	This practice is a dental discharger subject to this rule and does not place or remove amalgam except in limited emergency or unplanned, unanticipated circumstances <b>and</b> the facility serves the following primary function: ___ Orthodontics                      ___ Oral Pathology or Oral medicine                      ___ Periodontics ___ Prosthodontics                      ___ Oral & Maxillofacial Surgery                      ___ Oral & Maxillofacial Radiology <b>Complete Sections A and E Only</b>

### SECTION B - DESCRIPTION OF AMALGAM SEPARATOR OR EQUIVALENT DEVICE

<input type="checkbox"/>	My facility has installed one or more ISO 11143 compliant amalgam separators (or equivalent devices) that captures all amalgam containing waste from the above identified chairs in Section A where amalgam is placed or removed.												
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Make</th> <th style="width: 33%;">Model</th> <th style="width: 33%;">Year of Installation</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Make	Model	Year of Installation									
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<input type="checkbox"/>	My facility has one or more existing non-ISO compliant amalgam separators installed prior to June 14, 2017 at the number of chairs indicated above, at which amalgam placement or removal occurs. I understand that it must be replaced with one or more ISO 11143 compliant amalgam separators (or equivalent devices), after its lifetime has ended or by June 14, 2027 (whichever comes first).												
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**SECTION C - DESIGN, OPERATION AND MAINTENANCE OF AMALGAM SEPARATOR/EQUIVALENT DEVICE**

<input type="checkbox"/>	Yes	The amalgam separator (or equivalent device) is designed and is operated and maintained to meet the requirements in 40 CFR §441.30 or §441.40.
A third-party service provider is under contract with this facility to ensure proper operation and maintenance in accordance with 40 CFR § 441.30 or § 441.40.		
<input type="checkbox"/>	Yes	Name of service provider: _____
<input type="checkbox"/>	No	If no, provide/attach a description of the practices employed by the facility to ensure proper operation and maintenance in accordance with 40 CFR § 441.30 or § 441.40.

**SECTION D – MANDATORY BEST MANAGEMENT PRACTICES**

<input type="checkbox"/>	This dental practice has implemented the following federally mandatory Best Management Practices (BMPs) and will continue to do so:
	<ul style="list-style-type: none"> <li>Waste amalgam including, but not limited to, dental amalgam from chairside traps, screens, vacuum pump filters, dental tools, cuspidors, capsules, and collection devices, is not discharged to the sanitary sewer. Such items are not rinsed in a sink or other sanitary sewer connection.</li> <li>Dental unit water lines, chair-side traps, and vacuum lines are not cleaned with oxidizing or acidic cleaners, including but not limited to bleach, chlorine, iodine, and peroxide that have a pH lower than 6 or greater than 8.</li> </ul>

**SECTION E – CERTIFICATION STATEMENT**

<p><i>"I, _____, am a duly authorized representative of the above named dental facility, and certify under penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those persons directly responsible for gathering the information, the information submitted is, to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for knowing violations."</i></p>	
Authorized Signatory Name:	
Signature:	Date:

**Return completed form to:**  
 Central Contra Costa Sanitary District  
 Attn: Environmental Compliance  
 5019 Imhoff Place  
 Martinez CA 94553