SECTION A – BUSINESS NAMES AND CONTACTS

Name of Dental Practice:		
Legal Name of Dental Practice: (as it appears on Business License)		
Site Address of Dental Practice:	Unit	Zip Code:
Mailing Address (if different):		
City:	State:	Zip Code:

Property owner name: _____
(if different than above)

Property owner address: _____

City: _____ State: _____ Zip Code: _____

Date Dental Practice started at this site:

PRIMARY PERSON TO BE CONTACTED ABOUT THIS SURVEY: (Please Print)

Name	Title (e.g., Owner, Office Manager, Property Manager)

Mailing Address: _____
(if different than above)

City: _____ State: _____ Zip Code: _____

Phone:	24-Hour Emergency Phone (Optional):
E-mail Address:	

Number of employees	
Full-Time	Part Time

Number of Patients per year (last 3 years)	
Year	# Patients

SECTION B – GENERAL BUSINESS INFORMATION

Complete the following for each dentist practicing at this location. If you require additional space, please attach a separate list. (Please Print)

Name of Dentist	Type of Practice (use letter in list below)	Identify Days open by listing the hours practicing those days.							Number of practicing days/year
		Mon	Tue	Wed	Thur	Fri	Sat	Sun	
1.									
2.									
3.									
4.									
5.									

Type of practice(s):

A. General Dentistry	E. Prosthodontics	I. Oral and maxillofacial Surgery
B. Pediatric Dentistry	F. Orthodontics & Dentofacial Orthopedics	J. Dental Hygiene
C. Periodontics	G. Oral and maxillofacial Pathology	K. Dental Lab
D. Endodontics	H. Oral and maxillofacial Radiology	O. Other(describe):_____

Refer to the line number above (with the dentist name) and provide the approximate number of amalgam fillings the dentist places and removes EACH MONTH (attach additional sheet if necessary).		
1. ____ Placed	____ Removed	☐ Neither
2. ____ Placed	____ Removed	☐ Neither
3. ____ Placed	____ Removed	☐ Neither
4. ____ Placed	____ Removed	☐ Neither
5. ____ Placed	____ Removed	☐ Neither

Year	Amalgam purchased (last 3 years)	E = estimated K = known
	grams	
	grams	
	grams	

SECTION C – PRODUCT AND PROCESS DESCRIPTION

Practice Activity	Yes	No	How many?	How often cleaned or changed?
X-ray fixer solution?				
Restorative chair?				
Hygiene-only chair?				
Cuspidor?				
Turbine vacuum pump?				
Air-water separator?				
Liquid ring vacuum pump?				
Re-circulating Liquid ring vacuum pump?				
Other vacuum/suction pump?				
Sterilizer/Autoclave?				
Amalgam Separator Installed?			*	
Manufacturer:				
Make and model number:				
Type:	☐ 1: Centrifugal system ☐ 2: Sedimentation system ☐ 3: Filter system ☐ 4: Any combination of types 1, 2 and 3			
Date installed:				
Date last serviced:				
Serviced by:				
Where is waste disposed:				

***** If more than one - attach additional sheet with applicable information.

SECTION D – WASTE GERERATION/DISPOSAL

Indicate by "X" for each disposal practice (more than one may apply)

Disposal Practice	Scrap amalgam	Empty capsules	Amalgam extracted teeth	Chair traps	Vacuum pump screens/filters	Sterilizing solutions	Other (identify)
Trash							
Sink/Drain							
Placed in a container for amalgam recycling							
Placed in container as hazardous waste							
Placed in red bags as medical waste							
Other (describe):							
Not applicable:							

Indicate by "X" how this practice handles the waste materials generated

Waste type	Sink drain	Pick-up Service	Mail or Ship	Other (describe)	Not applicable
Recycle					
Hazardous waste					
Medical waste					
X-ray fixer					

How frequently does this practice dispose of the wastes?

	Frequency
Recycled waste	
Hazardous waste	
Medical waste	
X-ray fixer	

SECTION E – COMPLIANCE OPTIONS

Dental practices will be required to implement Best Management Practices (BMPs) and install an amalgam separator to comply with the City's Wastewater Treatment Plant discharge limit of 0.008 ug/L for total mercury.

This dental practice:

☐ has installed an ISO 11143 amalgam separator.

☐ has installed an amalgam separator, but do not know if it is an ISO 11143 amalgam separator.

☐ will install an ISO 11143 amalgam separator.

☐ does not place or remove dental amalgam fillings and is requesting an exemption from the permit process.

*[**Note**: All relevant sections of the Survey must be completed. The City may exempt a dental practice that does not place, remove or use amalgam. The granting of an exemption may be contingent upon the completion of an inspection by City staff.]*

SECTION F – CERTIFICATION

This certification must be signed by a person who is legally responsible for the practice.

I 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 ensure 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.

Signature	Title
Printed Name	Date