TOWN OF WELLINGTON

Public Works Department

Dental Survey

Please complete this one-time industry specific questionnaire and attach it to your completed survey.

General Information

Name of Facility: _____
Physical Address of Dental Facility: _____
City: _____ State: _____ Zip: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Facility Contact: _____
Phone: _____ Email: _____

Name of Owner(s): _____
Name(s) of all Practicing Dentist(s) & Contact information:
Name: _____ Phone: _____ Email: _____
Name: _____ Phone: _____ Email: _____
Name: _____ Phone: _____ Email: _____
Name: _____ Phone: _____ Email: _____
Name: _____ Phone: _____ Email: _____

Applicability: Please select one of the following:

☐ This facility is a dental discharger subject to this rule by Federal Regulation 40 CRF Part 441 as it places or removes dental amalgam. *Complete Sections A, B, C, D, and E.*

☐ This facility is a dental discharger subject to this rule and (1) it does not place dental amalgam, and (2) it does not remove amalgam except in limited emergency or unplanned, unanticipated circumstances. *Complete Section E only.*

(Also, select if applicable) Transfer of Ownership (§ 441.50(a)(4))

☐ This facility is a dental discharger subject to this rule (40CRF Part 441) and has previously submitted a Dental Survey. This facility is submitting a new One Time Compliance Report because of a transfer of ownership as required by Federal Regulation 441.50(a)(4).

Section A: Description of Facility

Total # of Chairs: _____

Total number of chairs at which amalgam may be present in the resulting wastewater (i.e., chairs where amalgam may be placed or removed): _____

Descriptions of any amalgam separator(s) or equivalent devices(s) currently operated:

_____

_____

_____

Did this facility discharge amalgam process wastewater prior to July 14th,2017, under any ownership?

☐ Yes ☐ No

Section B: Description of Amalgam Separator or Equivalent Device

☐ The dental facility has installed one or more ISO 11143 (or ANSI/ADA 108-209) compliant amalgam separators (or equivalent devices) that captures all amalgam placement or removal may occur:
Chairs: _____

☐ The dental facility prior to June 14, 2017, installed one or more existing amalgam separators that do not meet the requirements of Reg 441.30(a)(1)(i) and (ii) at the following number of chairs at which amalgam placement or removal occur:
I understand that such separators must be replaced with one or more amalgam separators (or equivalent devices) that meet the requirements of Regulation 441.30(a)(1) or 441.30(a)(2), after their useful life has ended, and no later than June 14, 2027, whichever comes first.
Chairs: _____

Make	Model	Year of Installation

☐ My facility operates an equivalent device.

Make	Model	Year of Installation	Average removal efficiency of equivalent device, as determined per Reg. 441.30(a)(2)i- iii.

Section C: Design, Operation and Maintenance of Amalgam Separator/Equivalent Device

☐ I certify that the amalgam separator (or equivalent device) is designed and will be operated and maintained to meet the requirements in Regulation 441.30 or 441.40.

Is a third-party service provider under contract with this facility to ensure proper operation and maintenance in accordance with § 441.30 or § 441.40.

☐ Yes, List name of the third-party service provider (e.g., Company Name) that maintains the amalgam separator or equivalent device (if applicable):

_____
_____
_____

☐ No If none, provide a description of the practices employed by the facility to ensure proper operation and maintenance in accordance with § 441.30 or § 441.40.

If no, describe practices:

_____
_____
_____
_____

Section E: Certification Statement

The undersigned is a principle or managerial agent for the survey respondent with authority concerning requirements for wastewater discharge from the facility.

I hereby certify, under penalty of law, that this document and all of its attachments were prepared under my direction or supervision according to a process designed to ensure that qualified personnel properly gather and evaluate the information submitted. The information is, to the best of my knowledge and belief, true, accurate, and complete.

Name: _____ Title: _____

Signature: _____ Date: _____

Name of Authorized Representative (print): _____

Phone: _____ Email: _____

_____

Authorized Representative Signature: Date: