Dental Facility Mercury Survey

(Questions adapted from the American Dental Association’s Best Management Practices for Amalgam Waste.)

The Town/City of \_\_\_\_\_\_\_\_\_\_\_ is implementing a Mercury Minimization Plan per NPDES permit requirements. As a potential source of mercury your facility is being asked to complete and return the following survey questions. Thank you for your cooperation.

IF YOU DO NOT PLACE OR REMOVE AMALGAM FILLINGS CHECK HERE: \_\_\_\_\_\_\_ AND COMPLETE CERTIFICATION AT THE BOTTOM OF THE PAGE

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Has all bulk mercury been eliminated from stock at your dental office? |  |  |
| Does your dental office use precapsulated alloys? |  |  |
| Does you dental office recycle disposable amalgam capsules? |  |  |
| Does your dental office capture and recycle non-contact scrap amalgam? |  |  |
| Does your dental office capture and recycle contact amalgam including the contents of chair-side traps? |  |  |
| Does your dental office recycle contact amalgam retained by the vacuum pump filter? |  |  |
| Does your dental office disinfect and recycle extracted teeth with amalgam fillings? |  |  |
| Does your dental office use non-chlorine, non-bleach cleaners that minimize dissolution of amalgam? |  |  |
| Does your dental office have and maintain an amalgam separator meeting ISO standards?Manufacturer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Model: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

Name and address of vendor where amalgam is recycled: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vendor contact name, email, phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have personally examined and am familiar with the information submitted in this document and attachments. Based upon my inquiry of the individuals immediately responsible for obtaining the information reported herein, I believe that the submitted information is true, accurate and complete.

Name of Facility Address Size of facility (No. of chairs, employees, etc.)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Name of Official (printed) Signature Title Date Phone

Return completed survey to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_