Medical Facility Mercury Survey

(Questions adapted from the American Hospital Association’s “Making Medicine Mercury Free” criteria)

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.

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Has your facility established a mercury plan to reduce and eventually eliminate mercury containing equipment and chemicals? |  |  |
| Has you facility developed a ”Mercury Free Purchasing Policy”? |  |  |
| Has your facility established mercury management protocols for safe handling, mercury spill cleanup and disposal procedures and education and training of employees? |  |  |
| Has your facility replaced patient mercury thermometers? |  |  |
| Has your facility replaced all or a majority (75%) of mercury containing sphygmomanometers? |  |  |
| Has your facility replaced all or a majority (75%) of mercury containing clinical devices (bougies, Miller-Abbott tubes, dilators)? |  |  |
| Has your facility inventoried mercury containing pharmaceuticals? |  |  |
| Has your facility inventoried and labeled all mercury containing facility devices (switches, thermostats)? |  |  |
| Has your facility implemented a program to recycle fluorescent lamps? |  |  |
| Has your facility implemented a battery collection program? |  |  |
| Has your facility replaced all or a majority (75%) of mercury lab thermometers? |  |  |
| Has your facility replaced b5/Zenkers stains with non-mercury substitute? |  |  |
| Has your facility inventoried mercury containing lab chemicals? |  |  |

Name, email address and phone # of facility contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 beds, employees, etc.)

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