Compliance Monitoring Division
4200 SE 24th Street
Ocala, FL 34471
Phone: 352-351-6772

Water Resources

Dental Amalgam Survey

Section A: General Information (Required for all Facilities)

Facility Name:	FL Board of Dentistry License Number:	
Operator(s) Name(s):		
Owner(s) Name(s)		
Facility Street Address:		
City:	Zip Code:	
Facility Phone:	Facility Email:	
Mailing Street Address:		
City:	State:	Zip Code:

Section B: Facility Information (Required for all Facilities)

1. Describe the facility's Primary Operation: _____

2.

Please answer the following questions pertaining to your facility:	Yes	No
Does your facility discharge dental amalgam wastewater to the City of Ocala? If not, please specify how your dental amalgam wastewater is disposed.		
Does your office work with or expect to work with dental amalgam (not including limited emergency or unplanned, unanticipated circumstances) or generate any wastewater associated with dental amalgam?		

If you answered "no" to <u>either</u> question, please sign and date the certification statement in Section C, and return this survey to the Compliance Monitoring Division. Otherwise, continue to question 3.

3.

Please answer the following questions pertaining to the type of practice:	Yes	No
Does your office exclusively practice one or more of the following dental specialties: oral pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics, periodontics, or prosthodontics?		

If you answered "yes", to <u>above</u> question, please sign and date the certification statement in Section C, and return this survey to the Compliance Monitoring Division. Otherwise, continue to Section D – Amalgam Information

Section C: Certification Statement for Dental Offices Not Subject to 40 CFR Part 441

This certification statement is for facilities that have indicated that they are NOT subject to this rule.

Please note if in the future there is a transfer of ownership, the new owner must submit a new Dental Amalgam Survey to the Compliance Monitoring Division no later than 90 days after the transfer.

Upon completion of Section C, please return this survey to the Compliance Monitoring Division.

I, _____ , the authorized representative* of the facility located at _____ hereby certify that my facility (please check all applicable boxes below):

- ☐ does not discharge dental amalgam wastewater to the City of Ocala.
- ☐ does not place dental amalgam and does not remove dental amalgam except in limited circumstances. Limited circumstances are defined as limited emergency or unplanned, unanticipated circumstances.
- ☐ exclusively practices one or more of following: oral pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics, periodontics, or prosthodontics
- ☐ is a mobile unit.

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 assure that qualified personnel properly gather and evaluated the information submitted. Based on my inquiry of the person or persons who managed 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: _____ Date: _____

Printed Name:

*Note: An authorized representative is (1) a responsible corporate officer if the dental office is a corporation; (2) a general partner or proprietor if the dental office is a partnership or sole proprietorship; or (3) a duly authorized representative of the responsible corporate officer, or general partner or proprietor.

Section D: Amalgam Information (Required for Facilities that Work with Dental Amalgam)

1. How many chairs in your office are associated with dental amalgam?	
2. What is the estimated wastewater flow rate, in gallon per day (gpd) associated with dental amalgam?	gpd
3. Does your facility have any amalgam separator(s) or equivalent devices installed for each chair associated with dental amalgam?	☐Yes ☐No

If no, please sign and date the certification statement is Section F and return the survey to the* Compliance Monitoring Division*. Otherwise, please continue.

Please include any amalgam separator or equivalent device information below:			
	Separator or Device #1	**Separator or Device #2**	**Separator or Device #3**
Is this an amalgam separator or equivalent device?	☐ Separator ☐ Device	☐ Separator ☐ Device	☐ Separator ☐ Device
Make			
Model			
Year of Installation			
How many chairs are associated with this separator or device?			
What is the maximum wastewater discharge rating of the separator or device?	_____ gallons per day ☐ Unknown	_____ gallons per day ☐ Unknown	_____ gallons per day ☐ Unknown
Is a third party maintaining this separator or device?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
The following 2 questions are only applicable to amalgam separators.			
Is this device compliant with ANSI/ADA specification 108 (2009)?	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Is this device compliant with the ISO 11143 Standards (2008)?	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
The following 2 questions are only applicable to equivalent amalgam removal devices.			
How many chairs are associated with this separator?			
Have at least a 95 percent removal efficiency (based on dry weight)?	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

If more than three amalgam separators or devices are installed or if additional explanations are needed, please include the additional information on a separate page.

Please provide additional information regarding the third-party maintenance company, if applicable

Maintenance Company Name:		
Maintenance Company Address:		
City:	**State:**	**Zip Code:**
Primary Contact Number for Maintenance Company:		
Primary Contact Email for Maintenance Company:		

If your office does not have a third party maintaining the amalgam separators, what practices does the office use to ensure proper operation and maintenance?

4.

Please indicate whether you implement any of the following Best Management Practices (BMPs) in your office:	Yes	No
Ensuring that waste amalgam including, but not limited to, dental amalgam from chairside traps, screens, vacuum pump filters, dental tools, cuspidors, or collection devices, are **not** discharged to a POTW. [40 CFR 441.30(b)(1)]		
Ensuring that Dental unit water lines, chair-side traps, and vacuum lines that discharge amalgam process wastewater to a POTW 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 standard units. [40 CFR 441.30(b)(2)]		

If you answered "no" for either of these BMPs, you are required to begin implementing them by no later than July 14, 2020 to ensure proper compliance with the regulation at 40 CFR Part 441. In addition, please *sign and date the certification statement is Section F and return the survey to the Compliance Monitoring Division.*

If you answered "yes" to both of these BMPs, please continue to Question 5 and Section E.

5. Please include any additional BMPs implemented by your facility with this survey.

Section E: Certification Statement for Facilities Compliant with 40 CFR Part 441 Requirements

This certification statement is for facilities that have indicated that they have appropriate amalgam separators or equivalent devices associated with each chair associated with dental amalgam, and are in compliance with the BMP requirements of 40 CFR Part 441. By completing this survey (Sections A, B, D, and E) and signing this certification statement, your office will have satisfied the "One-Time Compliance Report" requirements as set forth in 40 CFR 441.50. Please note if in the future there is a transfer of ownership, the new owner must submit a new One-Time Compliance Report to the Compliance Monitoring Division no later than 90 days after the transfer.

Upon completion, please return this survey to the Compliance Monitoring Division.

I, _____ , an authorized representative* of the facility located at _____ hereby certify that all chairs associated with dental amalgam wastewater at this facility have (Please check all applicable boxes below):

- ☐ ***For amalgam separators installed prior to June 14, 2017***: amalgam separators installed prior to June 14, 2017 and I understand that these existing separators must be replaced in the event that the amalgam separator is not functioning properly or by June 14, 2027, whichever is sooner.
- ☐ ***For amalgam separators installed after June 14, 2017***: amalgam separators installed and the separators are designed and will be operated and maintained to be compliant with either ANSI/ADA Specification 108 for Amalgam Separators (2009). In addition, the separators are sized to accommodate the maximum discharge rate of amalgam process wastewater
- ☐ ***For amalgam removal devices***: amalgam removal devices installed and the devices have a removal efficiency of at least 95 percent and are sized to accommodate the maximum discharge rate of amalgam process wastewater.

In addition, I certify that the facility is (Please check all the applicable statements):

- ☐ In compliance with the BMP requirements set forth in 40 CFR 441.30(b)(1)
- ☐ In compliance with the BMP requirements set forth in 40 CFR 441.30(b)(2)

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 assure that qualified personnel properly gather and evaluated the information submitted. Based on my inquiry of the person or persons who managed 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: _____ Date: _____

Printed Name: _____ _____

*Note: An authorized representative is (1) a responsible corporate officer if the dental office is a corporation; (2) a general partner or proprietor if the dental office is a partnership or sole proprietorship; or (3) a duly authorized representative of the responsible corporate officer, or general partner or proprietor

Section F: For Dental Facilities Without Amalgam Separators and/or Established BMPs

This certification statement is for dental facilities that have not installed the necessary amalgam separator, have installed amalgam separator but the device does not meet the requirements of 40 CFR Part 441, or are not in compliance with the BMP requirements of 40 CFR Part 441.

I, _____ , an authorized representative* of the facility

located at _____

hereby 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 evaluated the information submitted. Based on my inquiry of the person or persons who managed 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: _____ Date: _____

Printed Name: _____ _____

*Note: An authorized representative is (1) a responsible corporate officer if the dental office is a corporation; (2) a general partner or proprietor if the dental office is a partnership or sole proprietorship; or (3) a duly authorized representative of the responsible corporate officer, or general partner or proprietor.

Please return completed Dental Amalgam Surveys to:

Compliance Monitoring Division
City of Ocala
4200 SE 24th Street
Ocala, FL 34471
Email: *bmoose@ocalafl.org*
Questions? Please contact City of Ocala Water Resources at 352-351-6772

For City of Ocala use only		
Is the Survey Complete?	Yes	No
Is follow-up necessary? If follow-up is necessary, specify follow-up requirements:	Yes	No
Is the facility subject to 40 CFR Part 441?	Yes	No
Comments:		
Reviewed by (Print Name):		Date:
Data Entered by (Print Name):		Date: