STATE WATER RESOURCES CONTROL BOARD
ONE-TIME COMPLIANCE REPORT
TO COMPLY WITH 40 CODE OF FEDERAL REGULATIONS PART 441.50
STANDARDS FOR THE DENTAL OFFICE CATEGORY

Instructions
If your local sanitation agency does not implement a federal Pretreatment Program, your dental facility must electronically submit this signed form to the State Water Resources Control Board by October 12, 2020 to DMR@waterboards.ca.gov, with the title "One-Time Compliance Report – Dental Amalgam Rule – *[Name of your Dental Facility]*" in the subject line.

If your local sanitation agency implements a federal Pretreatment Program and is the Control Authority, please contact the agency to obtain information on submitting the compliance report.

General Information:

Facility Name:_____ Facility Address: _____

Mailing Address (if different from above):_____

Facility Contact: _____ Phone: _____ Email: _____

Names of owner(s):_____ Names of operator(s): _____
if different from owner(s)

Applicability:

☐ I certify this facility does not place dental amalgam and does not remove amalgam except in limited circumstances. (Proceed to Section D of this Report).

Section A: Facility Description

Total number of chairs:_____

Total number of chairs at which amalgam may be placed or removed:_____

Section B: Description of Currently Operated Amalgam Separator or Equivalent Device

This facility has installed the following amalgam separator(s) (use additional sheets if necessary):

Make: _____ Model:_____ Installation Year:_____

This facility uses an equivalent device as described below (use additional sheets if necessary):

Make: _____ Model:_____ Installation Year:_____

Section C: Amalgam Separator or Equivalent Device Certification

☐ I certify that the amalgam separator (or equivalent device) is designed and will be operated and maintained to meet the requirements in Title 40 Code of Federal Regulations Part 441.30 and 441.40. If applicable, provide the name of third-party service provider that maintains the amalgam separator(s) or equivalent devices operated at the dental office: _____

If no third-party service provider is under contract, please provide a description of practices employed by the facility to ensure proper operation and maintenance.

_____

Section D: Management Practices Certification

☐ I certify this facility is implementing the management practices as specified in Title 40 Code of Federal Regulations Part 441.30(b) and 441.40:

Signature of Responsible Party:_____ Date:_____