



SURVEY OF AMALGAM MANAGEMENT

RETURN COMPLETED FORM BY **August 18, 2018**

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Dublin San Ramon Services District is a Regional Wastewater Treatment Facility serving the cities of Dublin, San Ramon, and Pleasanton under contractual agreement. This survey is to determine the use of “best management practices” and the number of installed amalgam separators in our service area.

SECTION 1 – BUSINESS NAME & ADDRESS:

NAME OF DENTAL PRACTICE	PRIMARY CONTACT FOR AMALGAM WASTE ISSUES: Name and Title (e.g., Owner, Consultant, Office Manager, Dental Assistant):
Site Address	Telephone No. Fax No. () - () -
City, State Zip Code	Email Address (Required for future correspondence)
City of Record on Dental License (if different from city in which practicing).	

PLEASE LIST ALL DENTISTS PRACTICING AT THIS DENTAL PRACTICE:

Name	# Days/Week	Which days of the week on site? (Circle all that apply)	Each MONTH, approximately how many amalgam fillings does this dental professional remove or place?
		M T W Th F Sa Su	#: ___ Placed ___ Removed <input type="checkbox"/> Neither
		M T W Th F Sa Su	#: ___ Placed ___ Removed <input type="checkbox"/> Neither
		M T W Th F Sa Su	#: ___ Placed ___ Removed <input type="checkbox"/> Neither
		M T W Th F Sa Su	#: ___ Placed ___ Removed <input type="checkbox"/> Neither
		M T W Th F Sa Su	#: ___ Placed ___ Removed <input type="checkbox"/> Neither

If there are more dentists in this practice, please attach a separate list.

SECTION 2 – TYPES OF SERVICES PROVIDED (Check All That Apply):

This facility provides the following service(s):

<input type="checkbox"/> General/Family Dentistry	<input type="checkbox"/> Oral pathology or oral medicine
<input type="checkbox"/> Orthodontics	<input type="checkbox"/> Endodontics
<input type="checkbox"/> Periodontics	<input type="checkbox"/> Prosthodontics
<input type="checkbox"/> Oral and maxillofacial surgery	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Radiology	

SECTION 3 –BEST MANAGEMENT PRACTICES FOR AMALGAM USE (See BMPs for details)

Check which of the following best management practices (BMPs) your office uses:

- Collects, stores, labels, packages, and recycles amalgam waste (scrap, traps, screens, used capsules & extracted teeth) in accordance with state and local regulations and recycler or hauler instructions.
Company name of amalgam recycler/hauler: _____ Phone #: _____ Frequency of pick-up of amalgam waste: _____
- Collects used chairside traps, vacuum pump screens, or amalgam separator canisters rather than rinsing in a sink or other sanitary sewer connection.
- Segregates amalgam and amalgam-containing waste items rather than including them with medical waste, regular solid waste, or plastic recycle containers.
- Trains staff in the proper handling and disposal of amalgam materials and x-ray waste solutions. Training records are available for inspection.
- When cleansing the vacuum system, uses bleach-free and chlorine-free products.
- Limits amount of amalgam triturated. Does not use bulk liquid mercury. Uses only precapsulated dental amalgam. Keeps variety of capsule sizes.

SECTION 4 – VACUUM SYSTEM(S) AND ASSOCIATED AMALGAM SEPARATOR EQUIPMENT

of operatories in this practice: _____

of vacuum pumps in this practice: _____

Location of vacuum pump(s): Pump 1: _____

Pump 2 (if applicable): _____

The vacuum system is:

- "Wet" system
- "Dry" system
- Don't know

Person or company who maintains the vacuum system (s)?

Person: _____

Company: _____

Phone: _____

Wet Vacuum System



Dry Vacuum System



- Vacuum lines from this dental practice are plumbed to another dental practice or to a shared building system.

Responsible party (e.g., name of landlord or other dental practice): _____

Phone: _____

Email: _____

Does your vacuum system include an amalgam separator device?

- YES**, this dental practice has installed an ISO 11143 certified amalgam separator device.

Brand: _____ Model: _____ Date of installation: _____

Frequency of amalgam waste removal and shipment: _____

Person responsible for maintenance: _____

- NO**, the vacuum system for this dental practice is **not** equipped with an amalgam separator.

The information submitted is, to the best of my knowledge and belief, true, accurate, and complete.

Printed Name: _____

Title: _____

Signature: _____

Date: _____