**Water Utilities Department**

**Pretreatment & Laboratory Services (PALS)**

**Mercury Best Management Practice (BMP) Compliance Report**

**ALL facilities MUST complete:**

**Dental Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mercury BMP ID:**

**Full Name(s) of Doctor(s) at Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Facility (physical) Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Operator/owner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NOTE: Transfers of ownership of a dental practice must submit a compliance report within 90 days of the transfer of ownership.**

**EXCLUDED DENTAL FACILITIES: Complete Section I, then continue to Section VI.**

**SECTION I**

**CERTIFICATION OF EXCLUDED DENTAL DISCHARGER CATEGORY**

***“I certify that this office practices one or more of the following practices exclusively: oral pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics, periodontics, prosthodontics, or mobile facilities.”***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(Dentist Name) (SIGNATURE) (DATE)**

**Facilities that do not place/remove amalgam, complete Section II, THEN PROCEED TO Section VI**

**SECTION II**

**CERTIFICATION OF NON-USE AND REMOVAL OF DENTAL AMALGAM:**

***“I certify that this office does not use or remove dental amalgam with/from its patients. I further certify that at this time, and in the future, no discharges of federally regulated process wastewater (dental amalgam) will be permitted to come from this location. I am certifying a “ZERO DISCHARGE” status of dental amalgam and/or dental amalgam waste except in limited emergency or unplanned, unanticipated circumstances. I will notify PALS immediately of any changes in operation at this location resulting in the potential for discharge of federally regulated process wastewater.”***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(Dentist Name) (SIGNATURE) (DATE)**

**Dental facilities not described in Sections I or II above MUST complete Sections III - VI.**

**SECTION III**

**DESCRIPTION OF DENTAL PRACTICE & CERTIFICATION OF AMALGAM SEPARATOR COMPLIANCE**

Total Number of dental chairs: \_\_\_\_\_\_\_\_\_\_\_ Chairs where dental amalgam may be present: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of wastewater (check all that apply):

Domestic  Dental wastewater

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of amalgam separator(s) present at facility: No Amalgam Separator Installed Check Here

Estimated Installation Date:

MAKE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MODEL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIZE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSTALLATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COMPLIANCE DESIGNATION (ANSI/ADA 108-2009: TA 2011 OR ISO 11143: 2008): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE: For facilities incorporating more than one separator, please include the above information for all amalgam separators in operation at the facility as necessary using provided form.**

**FOR THOSE FACILITIES WITH AN EXISTING AMALGAM SEPARATOR(S) (initial):**

**\_\_\_\_\_\_\_\_\_ My facility has one or more existing amalgam separators installed prior to July 14, 2017 at the following number of chairs at which amalgam placement or removal occurs [\_\_\_\_]. I understand that it must be replaced with one or more ANSI/ADA 108-2009: TA 2011 or ISO 11143:2008 compliant amalgam separators, after its lifetime has ended, and no later than July 14, 2027.**

**SECTION IV**

**OPERATION AND MAINTENANCE**

**Note for Operation and Maintenance Section: Attach separate inspection log AND all bills of sale/invoices from services for amalgam separator(s) for each unit installed at the facility to this report using provided form.**

**Business name of amalgam separator(s) service provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Service provider address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If no third-party service provider, provide a brief description of required maintenance practices to ensure compliance with 40 CFR §441.30 & §441.40 for operation and maintenance of device(s) described above:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CERTIFICATION OF ADHERENCE TO BEST MANAGEMENT PRACTICES**

**SECTION V**

***“I certify that the above named dental discharger is implementing the following BMPs as specified in §441.30 (b) and §441.40 (b) and will continue to do so.***

* ***Waste amalgam including, but not limited to, dental amalgam from chair-side traps, screens, vacuum pump filters, dental tools, cuspidors, or collection devices is not discharged to a publicly owned treatment works (e.g., municipal sewage system).***
* ***Dental unit water lines, chair-side traps, and vacuum lines that discharge amalgam process wastewater to a POTW must not be cleaned with oxidizing or acidic cleaners (including, but not limited to bleach, chlorine, iodine and/or peroxide that have a pH lower than 6 or greater than 8) that may increase the leaching of solid mercury.”***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(Dentist Name) (SIGNATURE) (DATE)**

**All facilities MUST complete Section VI:**

**SECTION VI**

**CERTIFICATION STATEMENT**

***“I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am a duly authorized representative of the above named dental facility, and 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 evaluate the information submitted. Based on my inquiry of the person or persons who manage 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.”***

**Name of Authorized Representative (Type or Print**) **Title**

**Signature of Authorized Representative**  **Date**

**Return this form to:**

**For further information on the Mercury BMP program contact:  
Environmental Coordinator (P: 214-670-9725)**

**Pretreatment Coordinator (P: 214-243-2362)**

**City of Dallas Water Utilities Department**

**Pretreatment and Laboratory Services Division**

**1020 Sargent Road, Building #2**

**Dallas, TX 75203**

**FAX: 214-243-2645 Attn: Mercury BMP**

**Email: dwupretreatment@dallascityhall.com**