City of Waupaca Dental Amalgam Program

Annual Report 20____ (Date interval here)

I. General Information

Dental Practice Name: _____ Permit Number: _____

Email Address: _____

Physical Address: _____

Mailing Address: _____

II. Amalgam Separator

Was your amalgam separator waste canister replaced or emptied during the past year?

☐ **YES**. The canister was replaced or emptied in the past year, and the name of the service provider, along with the dates of service are provided below:

Service Provider: _____

Address: _____

City State, Zip: _____

Dates Canister was replaced/emptied in the past year:

1) _____ 2) _____ 3) _____ 4) _____ 5) _____

☐ **NO**. The canister was NOT replaced or emptied in the past year and the reason is provided below.

☐ Canister was not full.

☐ Other (please explain)

_____

_____

_____

_____

Dental Amalgam Management Program
111 S. Main St., Waupaca, WI 54981
tel (715) 258-4420

III. Other Amalgam Waste

Did your facility dispose of other amalgam waste last year (i.e., used capsules, traps, screens, etc.)

YES. Please see below.

☐ YES. Our practice disposed of Other Amalgam Waste in 20____ and used the following hauler to collect it.

Hauler: _____

Address: _____

City,
State, Zip: _____

NO. Please see below.

☐ NO. Our practice did NOT dispose of Other Amalgam Waste in 20____, and the reason is provided below:

_____

_____

_____

_____

IV. Amalgam Separator Maintenance

Was routine maintenance performed on the amalgam separator during the past year? If so, please specify what was done.

YES. Choose ONE of the options below.

☐ 1. YES. We were able to perform maintenance in-house, following the manufacturer's instructions.

☐ 2. YES. We have a maintenance agreement with the manufacturer/supplier who performed service as necessary. .

NO. Choose ONE of the options below:

☐ 1. NO. Separator did not require any maintenance during the past year.

☐ 2. Other (please explain)

_____

_____

_____

_____

_____

Dental Amalgam Management Program
111 S. Main St., Waupaca, WI 54981
tel (715) 258-4420

V. Best Management Practices for Dental Amalgam

Does the staff at this dental facility understand and follow Best Management Practices?

☐ This dental practice has implemented and follows Best Management Practices for dental amalgam as established by the Wisconsin Dental Association.

VI. Certification Statement

"I certify under penalty of law that this document and all attachments were prepared under my direction in accordance with a system designed to ensure that qualified personnel properly collected and evaluated the information submitted. Based on my inquiry of the person or persons who manage the system, the information submitted is, to the best of my knowledge, accurate and complete."

☐ *By checking this box, I affirm that I am the Owner/Principal of this Dental Practice; and I understand that my name typed below represents my legally binding signature and my intent to sign, certify and uphold the provisions of the certification paragraph above.*

Name (typed or printed): _____

Name (signature): _____

Title: _____ Phone: _____

Date: _____