



DENTAL AMALGAM PROGRAM

For WPCP Use Only

DENTAL PRACTICE: _____

DATE RECEIVED: _____

SAN JOSE/SANTA CLARA WATER POLLUTION CONTROL PLANT

DENTAL WASTEWATER DISCHARGE PERMIT APPLICATION

Effective February 2008, the California Regional Water Quality Control Board requires all Municipal and Industrial Wastewater Dischargers to San Francisco Bay to implement a mercury reduction program that includes reduction of amalgam from dental offices.

In response to this requirement, all dental practices within the service area of the San Jose/Santa Clara Water Pollution Control Plant are required to obtain a Dental Wastewater Discharge Permit (Per Municipal Code)

Information about the program and its requirements can be found at:

<http://www.sanjoseca.gov/esd/wastewater/dental-amalgam-program.asp> or call:
The Dental Amalgam Program at (408) 945-3000

INSTRUCTIONS:

- Complete and sign this permit application.
- Submit this form to the address below within 30 days of receipt.

City of San José
Environmental Services Department
700 Los Esteros Road San José, CA 95134
Attention: Dental Amalgam Program

The certification section must be signed by a person who is legally responsible for the practice, usually the dentist who is the owner or president, if incorporated.

Inspection of the dental practice may occur to verify information in this application.

SECTION 1 – BUSINESS NAMES AND ADDRESSES (Please Print)

NAME OF DENTAL PRACTICE:			
LEGAL NAME OF DENTAL PRACTICE: (As appears on Business License)			
SITE ADDRESS OF DENTAL PRACTICE:		MAILING ADDRESS (if different):	
City, State	Zip Code	City, State	Zip Code

PRIMARY PERSON TO BE CONTACTED ABOUT THIS PERMIT APPLICATION: (Please Print)			
Name		Title (e.g., Owner, Office Manager, Property Manager)	
Mailing Address		Phone () -	
City, State	Zip Code	24-Hour Emergency Phone (Optional) () -	
E-mail Address		FAX No. () -	

LIST NAMES OF ALL DENTISTS PRACTICING AT THIS DENTAL PRACTICE: (Please Print)

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 you require additional space, please attach a separate list.

SECTION 2 – EXEMPTION FOR DE MINIMUS AMALGAM USE

If you are seeking designation as an EXEMPT dental practice, check the box below, indicate all specialties that apply, sign the form on page 4, and submit the application.

<input type="checkbox"/>	<p>I certify this dental practice is exempt from the amalgam management requirements because:</p> <p>1) amalgam fillings are removed or placed at this facility three or fewer days per calendar year, AND</p> <p>2) this practice serves the following primary function(s):</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> <p>() Endodontics</p> <p>() Oral pathology or oral medicine</p> <p>() Oral and maxillofacial surgery</p> <p>() Orthodontics</p> </div> <div style="width: 45%;"> <p>() Periodontics</p> <p>() Prosthodontics</p> <p>() Radiology</p> </div> </div>
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SECTION 3 – MANDATORY BEST MANAGEMENT PRACTICES FOR AMALGAM USE

This dental practice will be required to implement mandatory best management practices (BMPs). See the *Dentist’s Guide to the Dental Amalgam Program & Permit* brochure, available at www.sanjoseca.gov/esd/wastewater/dental-amalgam-program.asp for a list of BMPs.

I certify that this dental practice will implement mandatory Best Management Practices (BMPs) and submit a *Best Management Practices Certification* form within 90 days of the effective date of the Permit. (Note: Certification form will be mailed with your Permit.)

SECTION 4 – AMALGAM SEPARATOR EQUIPMENT

Please check the appropriate box below:

I certify that this dental practice will install an *approved amalgam separator*, which when tested is in accordance with the International Organization for Standardization’s (ISO’s) standard ISO 11143, attains 95% or more amalgam removal.

The current list of approved amalgam separators can be found at:
www.sanjoseca.gov/esd/wastewater/dental-amalgam-program.asp

1. This dental practice shall install an amalgam separator within 180 calendar days of the Permit’s effective date.
2. Upon installation, this dental practice will provide a completed *Amalgam Separator Installation Certification* (mailed with the Permit) to the City of San José, including the separator’s (a) manufacturer name, (b) brand name and model, (c) vendor name and telephone number, and (d) date of installation.

I certify that the vacuum lines from this dental practice are plumbed with another dental practice or to a shared building system and that the required amalgam separator equipment will be installed outside of this dental practice. I understand that proof of delegated responsibility may be required. The responsible party for the required amalgam separator is as follows:

The responsible party (e.g. name of landlord or other dental practice) for amalgam separator installation:

Name _____ Phone _____
Fax _____

Please list other dentists who share/will share the separator:

_____ Suite # _____
_____ Suite # _____
_____ Suite # _____
_____ Suite # _____

Note: Each dental practice is legally responsible for ensuring that an approved amalgam separator has been installed for a shared vacuum system.

I certify that this dental practice has an approved amalgam separator currently installed. Note: If the currently installed separator is not on the approved list of amalgam separators found at www.sanjoseca.gov/esd/wastewater/dental-amalgam-program.asp, contact the Dental Amalgam Program at (408) 945-3000.

SECTION 5 – CERTIFICATION STATEMENT

Municipal Code requires that permit applications and any other reports required by the Director shall be **signed by an Executive Officer of the business filing the application**. Such Executive Officer shall be at least of the level of Owner, President, Vice President, General Partner, or an individual responsible for the overall operation of the practice applying for the Permit, or meet the Federal requirements for NPDES applications as contained in Title 40 of the Code of Federal Regulations.

“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 ensure 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.”

This certification section must be signed by a person who is legally responsible for the practice, usually the practice owner or president.

CERTIFIED BY:

<i>Name (Print)</i>	<i>E-mail</i>
<i>Title</i>	<i>Phone</i>
<i>Signature</i>	<i>Date</i>