



**Dental Amalgam Program
Annual Report
January 1 through December 31, 2016**



Section A. General Information

To complete this form online visit:

www.sanjoseca.gov/dental

**Dental
Practice Name:**

**Permit
Number:**

**Email
Address:**

**Dental Office
Address
(include Suite):**

**Mailing Address
(include Suite):**

**Total number of
dental chairs in Office:**

**How many were used to place
AND/OR remove amalgam:**

☐ **We have moved!** We are no longer at the address above. Our new address is:

Section B. Amalgam Separator

Was your Amalgam Separator waste canister replaced or emptied in 2016?

- ☐ **Yes.** The canister was replaced or emptied in 2016 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 2016:

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

Please continue to Section C.

- ☐ **No.** The canister was **not** replaced or emptied in 2016 and the reason is provided below:

☐ Canister was not full.

☐ Other (please explain):

Please continue to Section C.



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Section C. Other Amalgam Waste

Did your practice dispose of Other Amalgam Waste (e.g., used capsules, chairside traps, vacuum pump screens, etc.) in 2016?

Yes. Choose **one** of the three options below.

☐ **1. Yes.** Our practice disposed of Other Amalgam Waste in 2016 and took it to the Santa Clara County Small Quantity Generator Program.

☐ **2. Yes.** Our practice disposed of Other Amalgam Waste in 2016 and used the following hauler to collect it:

Hauler: _____

Address: _____

City

State, Zip: _____

☐ **3. Yes.** Our practice disposed of Other Amalgam Waste in 2016 and mailed it to the following recycler:

Recycler: _____

Address: _____

City

State, Zip: _____

Please continue to Section D.

No. Please see below.

☐ **No.** Our practice did **not** dispose of Other Amalgam Waste in 2016 and the reason is provided below:

Please continue to Section D.



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Section D. Spent Fixer Solution

Does your practice have Spent Fixer Solution on site? If so, how was it disposed?

Yes. Choose **one** of the three options below.

- ☐ 1. **Yes.** Our practice disposed of Spent Fixer Solution by taking it to the Santa Clara County Small Quantity Generator Program.
- ☐ 2. **Yes.** Our practice disposed of Spent Fixer Solution by using the following hauler to collect it:

Hauler: _____

Address: _____

City
State, Zip: _____

- ☐ 3. **Other** (please explain):

No. Choose **one** of the three options below.

- ☐ 1. **No.** Our practice does not have any Spent Fixer Solution on site.
- ☐ 2. **No.** While our practice does have Spent Fixer Solution on site, we did not dispose of any in 2016.
- ☐ 3. **Other** (please explain):

Section E. Best Management Practices for Dental Amalgam

Does the staff at this dental practice understand and follow Best Management Practices for handling Dental Amalgam? Visit the website provided here to learn more about Best Management Practices for Dental Amalgam: www.sanjoseca.gov/Archive.aspx?AMID=172 or use the QR Code Below.



- ☐ This dental practice has implemented and follows Best Management Practices for dental amalgam as required for compliance with our Wastewater Discharge Permit.
- ☐ We have some questions about the Best Management Practices for dental amalgam and request a call from a dental inspector.

Please continue to Section F.



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Section F. Dentist Names and Days On Site

Please list all dentists and their days on site at this dental practice

Dentist Name Please attach an additional sheet if needed.	Dental License #	Which days of the week on site? Check all that apply.
		M <input type="checkbox"/> Tu <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa <input type="checkbox"/> Su <input type="checkbox"/>
		M <input type="checkbox"/> Tu <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa <input type="checkbox"/> Su <input type="checkbox"/>
		M <input type="checkbox"/> Tu <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa <input type="checkbox"/> Su <input type="checkbox"/>
		M <input type="checkbox"/> Tu <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa <input type="checkbox"/> Su <input type="checkbox"/>

Section G. Certification Statement

Municipal Code requires that reports required by the Director shall be **signed by the Owner or an Executive Officer of the business filing the report**. Such Executive Officer shall be at least of the level of Vice President, General Partner, President, or an individual responsible for the overall operation of the business.

"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."

Signature:	_____	Date:	_____
Name:	_____	Email:	_____
Title:	_____	Phone:	_____
Dental Practice Name:	_____	Dental Permit Number:	_____
Dental Office Address (include Suite):	_____		