



## ONE-TIME COMPLIANCE REPORT FOR DENTAL DISCHARGERS – TRANSFER OF OWNER FORM

Issued by the Madison Metropolitan Sewerage District, August 2018

This form is being issued by your control authority, the Madison Metropolitan Sewerage District, as a one-time compliance report required by *Effluent Limitations Guidelines and Standards for the Dental Office Category* (“Dental Amalgam Rule”), 40 CFR 441.50. Completed, this form also fulfills reporting requirements associated with the District’s Sewer Use Ordinance, Section 7.1.4.

This form should be completed as soon as possible and returned to the District promptly. You can send the completed form by email to [EmilyJ@madsewer.org](mailto:EmilyJ@madsewer.org) or by mail to:

**Madison Metropolitan Sewerage District**  
**ATTN: Emily Jones**  
**1610 Moorland Rd.**  
**Madison, WI 53713**

This form should be made available for inspection in either physical or electronic form. Retain a copy of this form as long as this facility is in operation, or until ownership is transferred. Upon transfer of ownership, the new owner is must submit a new One-Time Compliance Report within 90 days.

### 1. Previous Ownership Information

Please fill this section completely, a-b

a. Facility Name: \_\_\_\_\_

b. Name of Owner: \_\_\_\_\_

### 2. Current (New) Ownership Information

Please fill this section completely, a-f

a. Facility Name: \_\_\_\_\_

b. Physical Address of Dental Facility: (Address) \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

c. Mailing Address of Dental Facility: (Address) \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

d. Facility Contact: (name) \_\_\_\_\_

(Phone) \_\_\_\_\_ (Email) \_\_\_\_\_

e. Name of Owner: \_\_\_\_\_

f. Name of Operator(s), if different from owner: \_\_\_\_\_

\_\_\_\_\_

### 3. Applicability

40 CFR part 441 applies to dental dischargers, meaning, “a facility where the practice of dentistry is performed, including, but not limited to, institutions, permanent or temporary offices, clinics, home offices, and facilities owned and operated by Federal, state or local governments, that discharges wastewater to a publicly owned treatment works.”

Dental facilities that exclusively practice one or more of the following dental specialties: Oral pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics, periodontics, or prosthodontics are exempt from this rule; mobile dental units; and dental dischargers that do not discharge any amalgam process wastewater to a treatment plant (those which collect all dental amalgam process wastewater for transfer to a Centralized Waste Treatment facility), are exempt from the rule.

Please select one of the following:

- This facility is exempt for the following reason (check one):
- it exclusively practices a dental specialty including: Oral pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics, periodontics, or prosthodontics
  - it is a mobile unit
  - it discharges wastewater to a septic tank, not a treatment plant
  - all dental wastes are discharged to a holding tank or similar device for transfer to a Central Waste Treatment Facility

➔ *Skip to 5. Certification Statement on p. 4*

- This facility is a dental discharger subject to this rule and it does **not** handle (place and/or remove) any dental amalgam except in limited emergency or unplanned circumstances.

➔ *Skip to 5. Certification Statement on p. 4*

- This facility is a dental discharger subject to this rule (40 CFR Part 441), which handles (places and/or removes) dental amalgam.

Continue to **3. Facility Description** below

#### 4. Facility Description

Please fill this section completely, items a.-g.

- a. \_\_\_\_ Total number of chairs at this facility
- b. \_\_\_\_ Number of chairs at this facility at which amalgam may be placed or removed
- c. Does this dental facility have one or more ISO 11143 (or ANSI/ADA 108-2009) compliant amalgam separator(s) installed?  
 Yes       No
- d. Does this dental facility operate one or more devices equivalent to an amalgam separator?  
 Yes       No
- e. Please describe the separator(s) or equivalent device(s) installed at this facility:
1. *Make* \_\_\_\_\_ *Model* \_\_\_\_\_ *Date of Installation* \_\_\_\_\_
2. *Make* \_\_\_\_\_ *Model* \_\_\_\_\_ *Date of Installation* \_\_\_\_\_
3. *Make* \_\_\_\_\_ *Model* \_\_\_\_\_ *Date of Installation* \_\_\_\_\_
- f. I certify that the amalgam separator or equivalent device at this facility is designed and will be operated and maintained to meet the requirements in § 441.30 or § 441.40 (see blue insert for text of these sections of the rule).  
 Yes       No
- g. Please describe practices employed to ensure proper operation and maintenance in accordance with § 441.30 or § 441.40 in the space below:

Measures taken by the facility – please describe practices.

**Or**

If a third-party service provider is under contract with this facility to ensure proper operation and maintenance in accordance with § 441.30 or § 441.40. Please list third-party service provider name.

**5. Best Management Practice Verification**

a. 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 the sewer system.

Yes             No (amalgam waste is discharged to the sewer system)

b. This facility uses a neutral pH line cleaner (pH between 6 and 8) that is approved for use with amalgam separators on all water lines, chair-side traps, and vacuum lines that discharge amalgam process wastewater.

Yes             No

c. Records of amalgam separator inspection, repair, replacement, waste manifest, and amalgam separator’s manufacturer operating manual are retained in either physical or electronic copy at this facility for a minimum of three years.

Yes             No

**6. Final Certification Statement**

*I certify that, “I am a responsible corporate officer, a general partner or proprietor (if the facility is a partnership or sole proprietorship), or a duly authorized representative in accordance with the requirements of § 403.12(l) 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.”*

Authorized Representative Name (print): \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_