

ANNUAL DENTAL WASTE DISPOSAL REPORT

(covering January 2002 through December 2002)

THANK YOU FOR YOUR ASSISTANCE IN REDUCING POLLUTANTS REACHING OUR WATERWAYS.

Please answer the questions and correct facility information as necessary. If you have comments or additional information, please attach a second sheet.

Sign and return to our office, postmarked by February 21, 2003.

MAILING ADDRESS

RWQCP ID NUMBER:

FACILITY ADDRESS (if different)

CONTACT PERSON:

PHONE NUMBER:

FAX NUMBER:

NAMES OF DENTISTS IN PRACTICE: _____

SILVER-BEARING X-RAY WASTE

1. List outside dental office using the x-ray equipment & photo waste disposal: _____
2. How many gallons of spent photo solutions are currently stored at your facility? _____ gallons
3. Has spent photo waste been hauled from your facility? **YES / NO** If yes, please fill out table below.

| DATE | VOLUME HAULED (Data can be found on invoices or manifests) | HAULER | MANIFEST NUMBER (Required if average is more than 27 gal/mo) |
|------|---|--------|---|
| | gal | | |
| | gal | | |
| | gal | | |
| | gal | | |
| | TOTAL _____ gal | | |

AMALGAM AND LEAD WASTE

Please identify your amalgam & lead waste management contractor: _____

Please identify which wastestreams are collected by that contractor (for items not applicable, write "NA"):

- | | | |
|----------------------------|-------------------------------|---------------------------------|
| ___ Scrap amalgam | ___ Chairside traps & screens | ___ Vacuum pump traps & screens |
| ___ Empty amalgam capsules | ___ Extracted teeth | ___ Lead x-ray foils |

I have reviewed the information submitted in this report and believe it to be true, accurate, and complete. In addition, our facility currently meets all applicable photo and amalgam waste requirements imposed by the Regional Water Quality Control Plant.

Name/Title of Responsible Person (Print)

Signature

Date