**City of Sioux City Wastewater Treatment Plant**

**Dental One-Time Compliance Certification**

**pg. 1 of 3**

In accordance with federal and local law (Title 40 of the Code of Federal Regulations Part 441, this form must be completed and returned by the following due dates:

* **New Dental Dischargers: Submit within 90 days after opening**
* **Existing Dischargers: Submit no later than October 12, 2020**

Complete one form per physical location/address and submit form to:

**City of Sioux City Wastewater Treatment Plant**

**ATTN: Craig Samek**

**3100 S. Lewis Blvd.**

**Sioux City, IA 51106**

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| **Section A: Exemptions Claim** | | | | | |
| **Your dental practice may qualify for an exemption from an amalgam separator if you meet one of the following exemptions. Mark the check box to certify each exemption claimed. If claiming an exemption, you may skip Section D.** | | | | | |
|  | The dental business exclusively practices one or more of the following specialties: oral pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics, periodontics, or prosthodontics. | | | | |
|  | The dental business conducts all dental services from one or more mobile units (defined as a specialized mobile self-contained van, trailer or other mobile unit) and/or hauls all dental amalgam process wastewater to a Centralized Waste Treatment facility that is not discharged to a publicly-owned treatment works. | | | | |
|  | The dental business does not place or remove dental amalgam, except in emergency or unplanned circumstances (less than 5% of the removal procedures involve dental amalgam and the facility does not stock amalgam capsules or accept new patients with amalgam fillings). | | | | |
| **Section B: General Information** | | | | | |
| Facility  Name: | |  | | | |
| Physical Address: | |  |  |  |  |
| Street | City | State | Zip |
| Mailing Address (if different): | |  |  |  |  |
| Street | City | State | Zip |
| Contact Information: | |  |  | | |
| Name | Title | | |
|  |  | | |
| Phone | Email | | |
| Owner(s): | |  | | | |
| Operator(s): | |  | | | |
| Number of Chairs in Facility | | | | |  |
| Number of Chairs Amalgam may be present in resulting Wastewater | | | | |  |

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| **Section C: Required Documentation** | |
|  | **This facility will maintain the following documentation (as applicable) to make available upon the request of the City of Sioux City Wastewater Treatment Plant:** |
| * A copy of this document, The “One Time Compliance Report”. * Relevant inspections from the past 3 years including dates, persons conducting investigations, results of inspections, and a summary of follow-up-actions if required. * Any amalgam container replacement documentation. * All dates that collected dental amalgam is picked up or shipped for proper disposal and the name of the permitted or licensed treatment, storage, or disposal facility receiving the amalgam containers. * Any repair or replacement of an amalgam separator or equivalent device, including the date, person making the repair or replacement, and the description of the repair or replacement (including make and model). * A manufacturers operating manual for the amalgam separator and containers. | |

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| **Section D: Amalgam Seperator** | | | | | | | | | |
| Has this practice installed one or more amalgam separators ISO 11143 (or ANSI/ADA 108-2009) compliant amalgam separators (or equivalent devices) to capture amalgam with at least a 95% efficiency rating from the above identified chairs in Section B. The amalgam separator (or equivalent device) is designed, operated, and maintained in accordance with the manufacturer’s operating manual. | | | | | | | | | |
| Yes | If yes, complete remainder of form. | | No | | If no, hold onto form until this practice has installed an amalgam separator(s) which meets ISO 11143 (or ANSI/ADA 108-2009). This must be completed before July 20, 2020.\* | | | | |
|  | **This dental practice is implementing the following Best Management Practices:**   * Waste amalgam is not discharged to a publicly owned treatment works. * Water lines are not cleaned with oxidizing or acidic cleaners. Cleaners including, but not limited to, bleach, chlorine, iodine, and peroxide that have a pH lower than 6 or greater than 8 (i.e. cleaners that may increase the dissolution of mercury). | | | | | | | | |
| In the space below provide a description of the practice employed by the facility to ensure proper operation and maintenance of the amalgam separator. | | | | | | | | | |
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| Third Party Service Provider for Separator Maintenance (if applicable): | | | | | | | | | |
|  | | | |  | | | |  | |
| Company | | | | Contact Name | | | | Phone | |
| Current Operational Amalgam Separator(s) or Equivalent Equipment | | | | | | | | | |
| Make | | Model | | | | Year Installed | ISO 11143 Compliant  (Yes or No)\* | | Average Removal Efficiency |
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*\*If a separator was installed that is not ISO 11143 compliant prior to June 14, 2017, it must be replaced with an ISO 11143 compliant amalgam separator (or equivalent device) before the manufacturer’s scheduled lifetime has ended or before June 14, 2027, whichever date is sooner. Complete the entire form if this describes your dental practice. This facility must immediately install a separator that complies If this facility was opened after June 14, 2017.*

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| **Section E: Certification Statement** | | | |
| “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(I) of the above named dental facility, and certify under the penalty of the 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 possibilities of fine and imprisonment for knowing violations.” | | | |
| Authorized Representative Name (Print Name): | |  | |
| Phone: |  | Email: |  |
|  | |  | |
| Authorized Representative Signature | | Date | |

***Retention Period*; per** [**§ 441.50(a)(5)**](https://www.federalregister.gov/d/2017-12338/p-322)

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| As long as a Dental facility subject to this part is in operation, or until ownership is transferred, the Dental facility or an agent or representative of the dental facility must maintain this One Time Compliance Report and make it available for inspection in either physical or electronic form. |