## *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/dental**
or call: The Dental Amalgam Program at (408) 945-3000

The information provided on this form will aid the Dental Amalgam Program in determining which dentists work in partnership/association in the dental practice named in this application. One permit will be in effect for the dental practice.

**INSTRUCTIONS:**

- Complete and sign the original of this permit application. Attach additional page(s) if more space is required.
- Submit the signed form to the address below within 30 days of receipt.

City of San José
Environmental Services Department
200 E. Santa Clara Street, 7th floor
San José, CA 95113
*Attention: Dental Amalgam Program*

## SECTION 1 – BUSINESS NAMES AND ADDRESSES

| | |
|---|---|
| **NAME OF DENTAL PRACTICE:** | |
| **LEGAL NAME OF DENTAL PRACTICE:** | |
| **SITE ADDRESS OF DENTAL PRACTICE:** | **MAILING ADDRESS:** |
| City, State Zip Code | City, State Zip Code |

| **PRIMARY PERSON TO BE CONTACTED ABOUT THIS PERMIT APPLICATION:** | |
|---|---|
| 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

| 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 ☐Neither |
| | | M T W Th F Sa Su | #:____ Placed ____ Removed ☐Neither |
| | | M T W Th F Sa Su | #:____ Placed ____ Removed ☐Neither |
| | | M T W Th F Sa Su | #:____ Placed ____ Removed ☐Neither |
| | | M T W Th F Sa Su | #:____ Placed ____ Removed ☐Neither |

If there are more dentists in this practice, 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.

☐ **I certify this dental practice is exempt from the amalgam management requirements because:**
**1) amalgam fillings are removed or placed at this facility 3 or fewer days per calendar year, *AND***
**2) this practice serves the following primary function:**

**( ) Orthodontics**
**( ) Periodontics**
**( ) Oral and maxillofacial surgery**
**( ) Radiology**
**( ) Oral pathology or oral medicine**
**( ) Endodontics**
**( ) Prosthodontics**

**SECTION 3 – MANDATORY BEST MANAGEMENT PRACTICES FOR AMALGAM USE**
**This dental practice will be required to implement mandatory best management practices (BMPs) as detailed in the *A Dentist's Guide to the Dental Amalgam Program & Permit* brochure included with this application.**

☐ **I certify that this dental practice will implement mandatory Best Management Practices (BMPs) and submit a *Best Managements Practices Certification* form within 90 days of the effective date of the 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 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 effective date.**
2. **Upon installation, this dental practice will provide a completed *Amalgam Separator Installation Certification* 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 to 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 separtor is as follows:**

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

**Name _____** **Phone _____**
**Fax _____**

☐ **I certify that this dental practice has an approved amalgam separator currently installed. Please complete the Amalgam Separator Information on page 4. Include copies of the amalgam separator purchase receipt AND proof of installation with this form.**

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

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

| Amalgam Separator Information | |
|---|---|
| **Manufacturer Name** | |
| **Brand Name / Model** | |
| **Technology Utilized** (Check all that apply) | ☐ Filtration ☐ Settlement<br>☐ Ion Exchange ☐ Centrifuge |
| **Vendor Name** | |
| **Vendor Phone.** | (  )  - |
| **Installation Date** | |

**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 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."

**CERTIFIED BY:**

| | |
|---|---|
| *Name (Print)* | *Email* |
| *Title* | *Phone* |
| *Signature* | *Date* |