



SECTION 1 – BUSINESS NAME AND ADDRESS

Name of dental practice:	Phone Number:
Site address:	
Mailing address (if different from site address):	
Primary contact for amalgam waste issues:	
Name: _____ Title: _____	

SECTION 2 – MANDATORY BEST MANAGEMENT PRACTICES FOR AMALGAM USE

I certify that this dental practice has implemented the following mandatory best management practices (BMPs):

- Does not rinse chair-side traps, vacuum screens, or amalgam separator equipment in a sink or other sanitary sewer connection. Traps are placed in containers labeled “Amalgam Waste – To Be Recycled”.
- Does not place amalgam, elemental mercury, broken or unusable amalgam capsules, extracted teeth with amalgam, or amalgam-containing traps and filters with medical waste or regular solid waste.
- Limits amount of amalgam triturated to the closest amount necessary. Keeps a variety of capsule sizes.
- Trains staff in the proper handling and disposal of amalgam materials and fixer containing solutions; training records are available for inspection.
- Does not use bleach or other chlorine-containing disinfectants to disinfect the vacuum line system.
- Does not use bulk liquid mercury; uses only pre-capsulated dental amalgam.
- Collects, stores, labels packages and recycles amalgam waste in accordance with state and local regulations and recycler or hauler instructions.

Name of amalgam waste hauler/recycler: _____

CERTIFICATION

I certify under penalty of law that this document was 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, including the possibility of fine and imprisonment for knowing violations.

Printed Name _____ Title _____

Signature _____ Date _____

Return completed form to:

Mercury Reduction Program, Attn: Edda Marasigan, USD, 5072 Benson Road, Union City, CA 94587