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AMALGAM SEPARATOR INSTALLATION CERTIFICATION

Within 30 days of installation of an amalgam separator(s), an Amalgam Separator Installation Certification must be submitted to the Metro Wastewater Reclamation District (via mail, fax or scan and email to **scaldwell@mwrd.dst.co.us** or **srenter@mwrd.dst.co.us**).

Section 1 – Business Name and Addresses

Name of Dental Facility:		Phone Number:	
Site Address of Dental Facility		**Mailing Address (if different from site address)**	
Street Address:		Street Address:	
City:	Zip Code:	City:	Zip Code:
Name and title of primary contact for amalgam waste issues:			

Section 2 – Amalgam Separator System Installation – Provide information for each separator

Manufacturer of separator	Model name and number	Separator serial number	Is the separator ISO-11143 Certified?	% Removal	Number of chairs
			Yes ☐ No ☐		
			Yes ☐ No ☐		

Section 3 – Amalgam Separator Maintenance and Operation

All wastewater that contains dental amalgam or other sources of mercury is discharged through the above mentioned separator(s) which is properly sized for flow. This dental facility properly maintains and operates the amalgam separator(s) in accordance with manufacturer specifications, including necessary cleanings, cartridge or filter replacement and other required servicing. Records of service will be maintained for a minimum of three (3) years and will be made available for review upon request from the Metro District.

____________ Yes ____________ No

Section 4 – Certification Statement

This certification must be signed by an Authorized Representative of the facility as defined by the Metro District's *Rules and Regulations Governing the Operation, Use, and Services of the System*.

"This practice/facility has installed the necessary ISO-11143 certified amalgam separator(s), in accordance with requirements of the Metro District's Dental Amalgam Control Program. I certify that this document and all attachments were prepared under my direction or supervision to ensure that qualified personnel properly gather and evaluate the information submitted. I certify the information submitted is, true, accurate and complete."

____ ____

Signature of Authorized Representative Date

____ ____

Name (please type or print) Position or Title