2017 ANNUAL "NO AMALGAM WORK" CERTIFICATION
DENTAL AMALGAM CONTROL PROGRAM

Section 1 – Business Name and Address(es)

Name of Dental Facility:	Phone Number:
E-Mail:	Fax Number:
Site Address of Dental Facility	Mailing Address (if different from site address)
Street Address:	Street Address:
City: Zip Code:	City: Zip Code:
Name of business Operator(s) and Owner(s):	
Name and title of primary contact for amalgam waste issues:	

Section 2 – Waiver Request

Waivers are granted to dental facilities in which no dentist places or removes amalgams containing mercury and/or teeth containing amalgams with an associated discharge. This facility has been granted a waiver by the Metro District, but **must submit an annual certification of "no amalgam work" in order to maintain the waiver**. Failure to submit this certification will require the implementation of the required BMPs and the installation of an amalgam separator.

The dental practice of _____ does not place or remove amalgams or teeth containing mercury amalgams that generate wastewater discharge.

Form of Dentistry: _____

☐ Existing waiver, please renew. ☐ Request of waiver, please review.

Section 3 – 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 dental facility does not place or remove amalgams or teeth containing amalgam that generates wastewater discharge. 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, to the best of my knowledge and belief, true, accurate and complete."

_____ _____
Signature of Authorized Representative Date

_____ _____
Name (please type or print) Position or Title