



**ONE-TIME COMPLIANCE REPORT – EXEMPT
DENTAL AMALGAM CONTROL PROGRAM SECTION 6.16.1.7
EPA CODE OF FEDERAL REGULATIONS CFR 441.50**

DUE ON OR BEFORE OCTOBER 12, 2020, OR 90 DAYS AFTER TRANSFER OF OWNERSHIP

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:			
Type of Dentistry (Description of Operation):			

Section 2 – Qualifying Exemption Status

Certify by selecting the exempt category fitting your business operations below. The Metro District reserves the right to review and/or deny any exemption claims that do not match previously identified operations at your facility. Information may also be verified via an on-site inspection by our staff.

- Oral Pathology Oral & Maxillofacial Radiology Oral & Maxillofacial Surgery
 Orthodontics Periodontics Prosthodontics Mobile Dental Facility

This dental facility does not place any amalgam, **and** whose removal of teeth with amalgam comprises **less than 5 percent** of the dental facility's business

Section 3 – One-Time Compliance Report

This One-Time Compliance Report 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*, and **must be retained as long as the dental facility is in operation or until ownership is transferred**. This dental facility either falls into an exempt category of operations as listed above or is a facility that does not place any amalgams **and** whose removal of teeth with amalgam comprises **less than 5 percent** of the dental facility's business. I certify that this document and any 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