ONE-TIME COMPLIANCE REPORT – EXEMPT
DENTAL AMALGAM CONTROL PROGRAM SECTION 6.16.1.7
EPA CODE OF FEDERAL REGULATIONS CFR 441.50
DUE WITHIN 90 DAYS OF INITIAL DISCHARGE OR 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):	Date Business Opened at this Location:

Section 2 – Qualifying Exemption Status

Certify by selecting the exempt category fitting your business operations below. Metro 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 Metro'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 _____