**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 opened at this location under current owner: | |

## 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 does not place dental amalgam and does not remove dental amalgam except in limited emergency or unplanned, unanticipated circumstances as defined in CFR 441.10(c)(d)(e)(f). 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 _____