MASSACHUSETTS WATER RESOURCES AUTHORITY

Chelsea Facility
2 Griffin Way
Chelsea, Massachusetts 02150

Telephone: (617) 242-6000
Facsimile: (617) 371-1604

SENT ELECTRONICALLY

TO: **Holders of MWRA Group Permit for Dental Facilities**

FROM: Massachusetts Water Resources Authority, Toxic Reduction and Control (TRAC)

DATE: March 21, 2022

SUBJECT: 2022 - Dental Facility Biennial Compliance Report

Please, complete the attached MWRA D1-Dental Group Permit Biennial Compliance Report for calendar years 2020 and 2021. Complete the report based upon your dental operations during calendar years 2020 and 2021. **This Biennial Compliance Report must be completed and submitted to the MWRA's TRAC, by April 30, 2022.**

1) You must submit the signed original "wet" 2022-MWRA D1-Dental Biennial Compliance Report via mail to: **MWRA, Toxic Reduction and Control (TRAC), 2 Griffin Way, Chelsea, Massachusetts 02150-3334, Attention: 2022-D1-Permit - Biennial Compliance Report Submittal**.

2) You must submit, electronically the 2022-MWRA D1-Dental - Biennial Compliance Report and its supporting documents to: **TRACDental@MWRA.com**

Please remember:

- The report must be completed and signed by a responsible individual capable of certifying that the information is true, accurate, and complete.
- You must complete Pages 1 and 2 of the report, provide information regarding the Facility contacts and email addresses for Permit/Mailing and Billing.
- Completion and submittal of the report constitutes only partial compliance with your Group Permit for Dental Facilities (for instance, you must notify the MWRA in writing at least thirty (30) days before you close or move your facility or substantially change your operations). Refer to your permit for the other requirements with which you must comply.

Failure to submit a completed report may result in financial penalties and other enforcement. In general, the MWRA issues penalties to Group Permit holders who failed to complete and return the Group Permit Biennial Compliance Report on time or failed to submit the required log(s). Your completed report including the required log(s) must be received by the MWRA by April 30, 2022.

If you have any questions regarding the completion of this form, please submit your questions to: **TRACDental@MWRA.com**

MASSACHUSETTS WATER RESOURCES AUTHORITY
GROUP PERMIT BIENNIAL COMPLIANCE REPORT
Dental Facilities
(for calendar years 2020 and 2021)
Due Date: April 30, 2022

You must submit this completed signed original "wet" Biennial Compliance form to:

Massachusetts Water Resources Authority, TRAC
2 Griffin Way
Chelsea, MA 02150
ATTN: TRAC - D1 Permit

And you must submit this completed signed report form electronically via Email to: TRACDental@MWRA.com

Complete this form to update information you reported in your One-Time Only Report or Notice of Intent (NOI) Form. Answer all questions. If a question does not apply, please indicate N/A. Return the signed report and supporting documentation to the above address by the due date of **April 30, 2022. Failure to submit a completed form by April 30, 2022, may result in financial penalties and other enforcement actions.**

I**f you have any questions about completing this form**, please submit your questions to: TRACDental@MWRA.com

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General Information (Please correct and complete this information directly on this form)
MWRA Category: D1

MWRA Permit Number: _____
Name of Dental Facility: _____

Name of Owners(s)/Operator(s) of dental facility: _____
Owner's Address: _____
Owner's Telephone No.: _____
Owner's Fax No.: _____
Owner's Email: _____
Date of Ownership: _____
Date of Transfer of Ownership *(if applicable)*: _____
Date the dental facility was established at this location: _____

Dental facility ownership type:
☐ **Sole Proprietorship**
☐ **Partnership**
☐ **Corporation**
☐ **Government Agency**
☐ **Other Institutional Organization (provide institutional type)** _____

<u>Facility Information-Physical location for dental facility</u>
Facility Contact: _____
Facility Contact Title: _____
Facility Address: _____
Name of Maintenance Operator(s) if different from Owners(s): _____

Facility Telephone: _____
Facility Fax Number: _____
Facility E-Mail Address: _____

Permit Information (Primary person to contact for this form submittal)

Permit Contact: _____

Permit Contact Title: _____

Permit/Mailing Address: _____

_____

Permit Telephone: _____

Permit Fax Number: _____

Permit E-Mail Address: _____

Billing Information (Primary person to contact for billing issues)

Billing Contact: _____

Billing Contact Title: _____

Billing Address: _____

_____

Billing Telephone: _____

Billing Fax Number: _____

Billing E-Mail Address: _____

SECTION-A- ANWSER ALL QUESTIONS UNLESS OTHRWISE INDICATED

1. Type of discharge from the dental facility:

Check one: ☐ Discharge to sewer
☐ Discharge to holding tank (*if its content will be hauled away for off site disposal)*
☐ Discharge to septic tank (*if yes, is it ultimately discharged into the MWRA Sanitary Sewer System? Yes No)*

2. Provide all applicable North American Industry Classification System (NAICS) code(s) for the dental facility's discharge to the sewer *(check all that apply)*:

☐**YES** ☐**NO** 621210-(NAICS)-Offices of Dentists
☐**YES** ☐**NO** 62151-(NAICS)-Medical and Diagnostic Laboratories
☐**YES** ☐**NO** 621512-(NAICS)-Diagnostic Imaging Centers
☐**YES** ☐**NO** 339114-(NAICS)-Dental Equipment and Suppliers Manufacturing
☐**YES** ☐**NO** 339116-(NAICS)-Dental Laboratories
☐**YES** ☐**NO** 8071-(SIC Code)-Medical Laboratories, Clinical, X-Ray Laboratories (including dental)
☐**YES** ☐**NO Other** (if "**Yes**", provide below the NAICS code number(s) and description(s) below)

For "Other" Provide NAICS code number(s): _____

For "Other" Provide NAICS code description(s): _____

SECTION B- EXEMPTION

3. This dental facility does not generate or discharge wastewater from amalgam-related processes (e.g., facilities limited to oral and maxillofacial surgery, or orthodontic, periodontic and/or oral medicine practices) or a facility that uses mercury-free filling material and does not place or remove amalgam.
☐**YES** ☐**NO**

4. This dental facility does not place dental amalgam, and does not remove amalgam except in limited emergency or unplanned, unanticipated circumstances, and that certifies such to the MWRA.
☐**YES** ☐**NO** If "**Yes",** you must provide on average, the annual limited emergency or unplanned dishcarges(s) of amalgam process wastewater to the MWRA sanitary sewer system: _____

5. This dental facility does not discharge any amalgam process wastewater to the MWRA Sanitary Sewer System and instead transfers all amalgam process wastewater to a Centralized Waste Treatment Facility as defined in 40 CFR 437.
☐**YES** ☐**NO**

If **Yes**, provide the name and address of the Centralized Waste Treatment Facility. Also, provide the phone no. and email if known.

Name: _____

Phone Number: _____

Address: _____

E-Mail: _____

6. This dental facility discharges only wastewater to the MWRA sanitary sewer system generated from X-Ray developing by using hand tray processing.
☐**YES** ☐**NO**

***IMPORTANT!** **If the answers to any of the questions listed above (Question #3, #4, #5 or #6) is "YES", you qualify for an exemption. If you claim this exemption go directly to SECTION I, the CERTIFICATION STATEMENT at the end of this form; there are no other questions that you need to answer.**

-SECTION C- DESCRIPTION OF DENTAL PRACTICE

7. ☐YES ☐NO This dental discharger is subject to 40 CFR Part 441 and it places or removes dental amalgam.

☐YES ☐NO General Dentistry
☐YES ☐NO Pediatric Dentistry
☐ Other Dental Specialties (describe) _____

8.List all dentists practicing at this dental facility

	Name(s) of Licensed Dentist(s) currently in this practice	Number of Days/Week on site	Days of the week on site? (Check all that apply)
1	_____	_____	M☐ Tu☐ W☐ Th☐ F☐ Sa☐ Su☐
2.	_____	_____	M☐ Tu☐ W☐ Th☐ F☐ Sa☐ Su☐
3.	_____	_____	M☐ Tu☐ W☐ Th☐ F☐ Sa☐ Su☐
4.	_____	_____	M☐ Tu☐ W☐ Th☐ F☐ Sa☐ Su☐
5.	_____	_____	M☐ Tu☐ W☐ Th☐ F☐ Sa☐ Su☐
6.	_____	_____	M☐ Tu☐ W☐ Th☐ F☐ Sa☐ Su☐

SECTION C - DESCRIPTION OF DENTAL FACILITY

9. This dental facility practices dentistry out of a mobile unit.
☐**YES** ☐**NO**

10. This dental facility discharges wastewater to a septic system whose contents are hauled for discharge to a sanitary sewer in the MWRA Sanitary Sewer service area.
☐**YES** ☐**NO**

If Yes, provide the name, address, and telephone number of the hauler used. Also, provide Email address if known.

Name: _____
Phone Number: _____
Address: _____
E-Mail: _____

11. This dental facility discharges wastewater to a holding tank whose contents are hauled for discharge to a sanitary sewer in the MWRA Sanitary Sewer service area.
☐**YES** ☐**NO**

If Yes, provide the name, address, and telephone number of the hauler used. Also, provide Email address if known.

Name: _____
Phone Number: _____
Address: _____
E-Mail: _____

SECTION D - DESCRIPTION OF OPERATION OF THE DENTAL FACILITY

12. Does your dental facility use the following?

☐**YES** ☐**NO** Chair Side Traps. If **yes,** indicate total number of chairs: ____
☐**YES** ☐**NO** Secondary Vacuum Pump Filter
☐**YES** ☐**NO** Amalgam Separator
☐**YES** ☐**NO** Amalgam Capsules
☐**YES** ☐**NO** Other. If **yes**, describe: _____

13. Describe how this dental facility disposes of the amalgam particles recovered from the following (if applicable):

☐ Chair Side Traps, describe: _____

_____

☐ Secondary vacuum pump filters**,** describe: _____

_____

☐ Amalgam Separator, describe: _____

_____

☐ Other, describe: _____

_____

SECTION E - X-RAY PROCESSING & DISCHARGE INFORMATION

This section is used to describe all X-Ray processing discharges to the MWRA Sanitary Sewer System from your dental facility.

14. This dental facility develops all of its X-Rays digitally only. (If no, complete the remaining questions for this section. If yes, skip to (SECTION -I)
☐**YES** ☐**NO**

15. This dental facility performs a photo process generated from X-Ray processing which results in a discharge to the MWRA Sanitary Sewer System?
☐**YES** ☐**NO**

16. Indicate how this dental facility disposes of its fixer solution.

☐**YES** ☐**NO** Fixer solution is hauled from the facility

☐**YES** ☐**NO** Fixer solution is treated and discharged to the MWRA Sanitary Sewer

☐**YES** ☐**NO** Other. If Yes, describe: _____

17. If your X-Ray processing wastes go to a holding tank for later discharge to the MWRA Sanitary Sewer System by a waste hauler that is not a silver reclaimer, list the name and address of the hauler, the location of the discharge, and the average amount hauled for the discharge each month in gallons:

Average amount hauled each month in gallons: _____ Gallons/Month

Company Name: _____

Phone Number: _____

Address: _____

E-Mail: _____

18. List the name and address of the company that hauls and treats your waste before discharge and the average amount hauled each month in gallons.

Average amount hauled each month in gallons: _____ Gallons/Month

Name location of discharge: _____

Company Name: _____

Phone Number: _____

Address: _____

E-Mail: _____

SECTION F - OPERATIONAL CHARACTERISTICS FOR X-RAY PROCESSING

19. Describe the X-Ray processing at your dental facility:

Number of processors used at your dental practice: _____

Number of processing hours/day _____ hours/day

Number of processing days/week _____ days/week

20. What is your average wastewater discharge from the X-Ray processing operation, including rinse water, in gallons per day: _____ Gallons/Day

21. How did you determine the amount of your wastewater discharge?

☐**YES** ☐**NO** Water supply meter readings

☐**YES** ☐**NO** Manufacturers' processing specs

☐**YES** ☐**NO** Wastewater flow meter readings

☐**YES** ☐**NO** Calculated

☐**YES** ☐**NO** Estimated, describe method using calculation provided by manufacturer.

_____

_____

21. Where are your photo X-Ray wastes discharged?

☐**YES** ☐**NO** Floor drain

☐**YES** ☐**NO** Sink

☐**YES** ☐**NO** Stand pipe

☐**YES** ☐**NO** Other. If Other (check mark in Yes Box), describe method: _____

_____

SECTION E - OPERATIONAL CHARACTERISTICS FOR X-RAY PROCESSING (continued)

22. What silver recovery (pretreatment type) is used at your dental facility (indicate all that applies and indicate how many of each):

☐**YES** ☐**NO** Electrolytic. If Yes, how many? _____

☐**YES** ☐**NO** Metallic Replacement If Yes, how many? _____

☐**YES** ☐**NO** Ion Exchange If Yes, how many? _____

☐**YES** ☐**NO** Evaporation/Distillation If Yes, how many? _____

☐**YES** ☐**NO** Chemical precipitation If Yes, how many? _____

☐**YES** ☐**NO** Other. If Yes, how many? _____

For other, describe method: _____

23. What is the servicing schedule for the silver pretreatment system at your dental facility? (Check each applicable option below):

☐**YES** ☐**NO** Monthly

☐**YES** ☐**NO** Quarterly

☐**YES** ☐**NO** Annually

☐**YES** ☐**NO** Other (If Yes, Describe) _____

24. Provide your dental facility's hazardous waste generator Identification Number (if any):

_____

SECTION G - DESIGN, OPERATION, AND MAINTENANCE OF AMALGAM SEPARATOR OR EQUIVALENT DEVICE

The design, operation, and maintenance of the amalgam separator must meet the requirements in accordance with 40 CFR 441 and 310 CMR 73.00, whichever requirements are more stringent, and will continue to do so.

25. This dental practice has installed one or more ISO 11143 (or ANSI/ADA 108-2009) 40 CFR 441 and 310 CMR 73.00 compliant amalgam separators (or equivalent devices) that captures all amalgam containing waste at the following number of chairs at which amalgam placement or removal may occur: If Yes, provide the number of chairs.

☐**YES** ☐**NO** **If Yes, provide the number of chairs.**_____

26. This dental practice installed prior to June 14, 2017, one or more existing amalgam separators that do not meet the requirements of 40 CFR 441.30(a)(1)(i) and (ii) at the following number of chairs at which amalgam placement or removal may occur. If Yes, provide the number of chairs.

☐**YES** ☐**NO** **If Yes, provide the number of chairs.**_____

26a. If one or more existing amalgam separators that do not meet the requirements of 40 CFR 441.30(a)(1)(i) and (ii), I understand that such separators must be replaced with one or more amalgam separators (or equivalent devices) that meet the requirements of 40 CFR 441.30(a)(1) or Section 441.30(a)(2), with a removal efficiency of 98%.

☐**YES** ☐**NO**

SECTION G- DESIGN, OPERATION, AND MAINTENANCE OF AMALGAM SEPARATOR OR EQUIVALENT DEVICE (continued)

27. For each amalgam separator currently operating at the dental practice provide the following information:

	Unit 1	Unit 2	Unit 3	Unit 4	Unit 5
Name of Amalgam Separator Device	_____	_____	_____	_____	_____
Model Number	_____	_____	_____	_____	_____
Make	_____	_____	_____	_____	_____
Year of Installation	_____	_____	_____	_____	_____
ANSI of ISO Compliant)	☐ ☐ YES NO	☐ ☐ YES NO	☐ ☐ YES NO	☐ ☐ YES NO	☐ ☐ YES NO
Number of Chairs Serviced	_____	_____	_____	_____	_____

If you have more amalgam separators than the space provided, please list remaining units in the section below.

_____

SECTION G- DESIGN, OPERATION, AND MAINTENANCE OF AMALGAM SEPARATOR OR EQUIVALENT DEVICE (continued)

28. If your dental facility operates equivalent amalgam separator devices, please provide the following information:

	Unit 1	Unit 2	Unit 3	Unit 4	Unit 5
Name of Amalgam Separator Device					
Model Number					
Make					
Year of Installation					
Average removal efficiency of equivalent device as determined, by 40 CFR 441.30(a)(2)(ii)					
Number of Chairs Serviced					

If you have more equivalent devices than the space provided, please list remaining units in the section below. _____

SECTION G- DESIGN, OPERATION, AND MAINTENANCE OF AMALGAM SEPARATOR OR EQUIVALENT DEVICE (continued)

29. I certify that the amalgam separator (or equivalent devices) are designed and will be operated and maintained to meet the requirements in 40 CFR 441 and 310 CMR 73.00.
☐**YES** ☐**NO**

30. A third-party service provider is under contract with this practice to ensure proper operation and maintenance in accordance with 40 CFR 441 and 310 CMR 73.00.
☐**YES** ☐**NO** If **Yes**, provide the name of third-party service provider (e.g. Company Name) that maintains the amalgam separator or equivalent device (if applicable).

Company Name: _____

If **No**, provide a description of the practices employed by the dental practice to ensure proper operation and maintenance in accordance with 40 CFR 441 and 310 CMR 73.00.

_____

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_____

_____

SECTION H- BEST MANAGEMENT PRACTICES (BMPs) CERTIFICATIONS

31. Waste amalgam including, but not limited to, dental amalgam from chair side traps, screens, vacuum pump filters, dental tools, cuspidors, or collection devices, is not discharged to the MWRA sanitary sewer system.

☐**This facility does not discharge amalgam waste to the sewer.**

☐**This facility does discharge amalgam waste to the sewer.**

32. Waste amalgam including, but not limited to, dental amalgam from chairside traps, screens, vacuum pump filters, dental tools, cuspidors, capsules, and collection devices, is not discharged to the sanitary sewer. Such items are not rinsed in a sink or other sanitary sewer connection.

☐**This facility does not discharge amalgam waste to the sewer, no items are rinsed in the sink.**

☐**This facility does discharge amalgam waste to the sewer.**

33. .Dental unit water lines, chair side traps, and vacuum lines that discharge amalgam process wastewater to the MWRA Sanitary Sewer System are not cleaned with bleach, oxidizing or acidic cleaners that may increase the leaching of solid mercury.

☐**This facility does not clean dental unit water lines with bleach, oxidizing or acidic cleaners.**

☐**This facility does clean dental unit water lines with bleach, oxidizing or acidic cleaners.**

34. Dental unit water lines, chair-side traps, and vacuum lines are not cleaned with oxidizing or acidic cleaners, including but not limited to bleach, chlorine, iodine, and peroxide that have a pH lower than 6.5 or greater than 8.

☐**This facility does not clean dental unit water lines with cleaners with a pH lower than 6.5 or greater than 8.**

☐**This facility does clean dental unit water lines with cleaners with a pH lower than 6.5 or greater than 8.**

35. Amalgam waste is collected, packaged, labeled, stored, managed, and disposed in accordance with state and local regulations and recycler or hauler instructions.

☐ **This facility does collect and dispose of amalgam waste in accordance with state and local regulations.**

☐**This facility does not collect and dispose of amalgam waste in accordance with state and local regulations.**

SECTION H- BEST MANAGEMENT PRACTICES (BMPs) CERTIFICATIONS (continued)

36. Amalgam, elemental mercury, broken or unusable amalgam capsules, extracted teeth with amalgam, chair side traps, and vacuum system screens/filters are not disposed with medical waste or regular solid waste.

☐**This facility does not dispose of amalgam waste with medical or regular solid waste.**

☐**This facility does dispose of amalgam waste with medical or regular solid waste.**

37. Bulk liquid mercury is not used at this dental facility; this dental practice only uses pre-capsulated dental amalgam.

☐**This dental facility only uses pre-capsulated dental amalgam.**

☐**This dental facility uses bulk liquid dental amalgam.**

38. This dental facility trains staff in the proper handling, management and disposal of amalgam waste and other hazardous solutions.

☐ **This dental facility trains staff of the proper handling, management and disposal of amalgam waste and other hazardous solutions.**

☐ **This dental practice does not train staff of the proper handling, management and disposal of amalgam waste and other hazardous solutions.**

39. This dental facility maintains documentation of training.

☐**This dental practice maintains documentation of staff training.**

☐**This dental practice does not maintain documentation of staff training.**

SECTION I - CERTIFICATION STATEMENT

40. ***Only certain persons may sign the certification of this form:***

IMPORTANT! Only certain persons may sign the certification of this form:

(A) For a corporation, its (i) president, secretary, treasurer, or vice-president of the corporation in charge of a principal business function, or any other person who performs similar policy- or decision-making functions for the corporation, or (ii) the manager of one or more manufacturing, production, or operation facilities employing more than 250 persons or having gross annual sales or expenditures exceeding $25 million (in second-quarter 1980 dollars), if authority to sign documents has been assigned or delegated to the manager in accordance with corporate procedures.

(B) For a partnership or sole proprietorship, a general partner or proprietor.

(C) ***(C) By a duly authorized representative of an individual designated in paragraph (A) or (B) if: (i) the authorization is made in writing by the individual described in paragraph (A) or (B); (ii) the authorization specifies either an individual or a position having responsibility for the overall operation of the facility from which the Industrial Discharge originates, such as the position of plant manager or a position of equivalent responsibility, or having overall responsibility for environmental matters for the company; and (iii) the written authorization is submitted with this form.***

CERTIFICATION STATEMENT

I certify under penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those persons directly responsible for gathering the information, the information submitted is to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for knowing violations.

CERTIFIED BY:

Name (Print): _____

Signature: _____
(Name of the person whose signature is above)

Title: _____

Telephone No.: _____

Email Address: _____

Date: _____

END OF COMPLIANCE REPORT