



DENTAL CLINIC AMALGAM RECOVERY PROGRAM

GENERAL PERMIT APPLICATION FORM

General Information

Dental clinic name: _____
 Responsible dentist: _____
 Clinic address: _____
 Clinic phone: _____
 Email: _____
 Alternate contact: List below the person responsible for the amalgam separator if different from the responsible dentist.

Name and Title: _____
 Address: _____
 Phone: _____
 Email: _____

MDH X-Ray Registry ID: ____ - ____ (Format is XX-XXX or XX-XXXXX)

Clinic discharges wastewater to: city sanitary sewer septic tank

Please indicate how you would like the name (clinic or dentist) to appear on your Certificate of Compliance:

Do you operate other dental clinics in the seven-county metro area that are not registered with MCES?

____ Yes ____ No If yes, please attach information showing the clinic name(s) and address(es).

Dental Clinic Type (Check all that apply)

____ General Dentistry ____ Endodontic ____ Prosthodontic ____ Oral Radiology
 ____ Orthodontic ____ Periodontal ____ Oral Surgery ____ Oral Pathology

Dentist and Operatory Information

Number of full-time equivalent dentists: _____
 Number of operatories for amalgam placements or removals: _____
 Number of operatories for hygiene or other non-amalgam work: _____

Amalgam Separator Information

Separator 1

Separator 2

Separator manufacturer/distributor:		
Model name and/or number:		
Serial Number (main unit, not filter SN):		
Date of installation:		
Name of clinic if separator is shared:		

Waste Solids Handling (check and list below those responsible for handling waste amalgam and separator solids)

____ Clinic staff ____ Dental supply company ____ Other: _____
 ____ Contract company ____ Separator company

Carrier(s) shipping waste amalgam and separator solids: _____
 Company receiving waste amalgam and separator solids: _____

The dental clinic is responsible for ensuring the proper handling of waste amalgam and separator solids and should receive confirmation that these waste solids are received at the proper destination.

Email completed form to: iwpp@metc.state.mn.us