# MASSACHUSETTS WATER RESOURCES AUTHORITY

## DENTAL PRACTICE

## X-Ray Processing Discharge Information

Use this form to describe all X-ray processing discharges to the MWRA Sanitary Sewer System from your dental practice. The mailing address is: MWRA, Toxic Reduction and Control, 2 Griffin Way, Chelsea, MA 02150 or you can email it to TRAC@mwra.com.

**Dental Practice Name:** _____

**MWRA Permit No.:** _____

**Dental Practice Facility Address:** _____

**General Information for X-Ray processing**:

1. This dental practice develops **all** of its X-Rays **digitally?** ☐ **YES** ☐ **NO**
   If **NO**, complete the remaining questions. If **YES**, skip to the Certification Statement.

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

3. Indicate how this dental practice 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 system.

   ☐ **YES** ☐ **NO** If Other (check mark is in **YES** Box), describe the method _____

   _____

4. 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:
   Name of Hauler: _____
   Address: _____
   Location of discharge: _____
   Average volume in gallons hauled for discharge per month: _____ Gallons/Month

5. List the name and address of the company that hauls and treats your waste before discharge and the average amount hauled each month.
   Company Name: _____
   Address: _____
   Location of discharge: _____
   Average volume in gallons hauled for discharge per month: _____ Gallons/Month

**Operational Characteristics for X-Ray processing**:

6. Number of processors used at your dental practice _____
   Number of processing hours/day _____ Hours/Day
   Number of processing days/week _____ Days/Week

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

8. 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

   If Estimated (check mark is in **YES** Box), describe the method: _____
   _____

9. 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 the method _____
   _____

10. What silver recovery (pretreatment type) is used at your dental practice *(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**, describe and provide how many _____

    If Other (check mark in **YES** Box), describe the method _____
    _____

11. What is the servicing schedule for the silver pretreatment system at your dental practice? *(Select one):*
    - ☐ **YES** ☐ **NO** Monthly
    - ☐ **YES** ☐ **NO** Quarterly
    - ☐ **YES** ☐ **NO** Yearly
    - ☐ **YES** ☐ **NO** Other

    If Other (check mark in **YES** Box), describe the method _____ _____
    _____

12. Provide your dental practice's hazardous waste generator Identification Number (if any): _____

## CERTIFICATION STATEMENT

**As required by 360 CMR 10.009, this form shall be signed by a responsible corporate officer, a general partner or proprietor if the dental discharger is a partnership or sole proprietorship, or a duly authorized representative in accordance with the requirements of 40 CFR§ 403.12(l).**

> *"*I certify under the 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 upon 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."

## CERTIFIED BY:

_____
Name of Authorized Representative

_____
Signature

_____
Title

_____
Telephone Number

_____
Email Address

_____
Date

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The mailing address for this form is:

**Massachusetts Water Resources Authority (MWRA)**
**Toxic Reduction and Control (TRAC)**
**2 Griffin Way**
**Chelsea, MA 02150-3334**
**Email: TRAC@mwra.com**