Title 21 Chapter 15 of the District’s Municipal Regulations require that this Wastewater Discharge Questionnaire be completed and returned within 15 days of receipt, or as directed by DC Water. The completed and signed application shall be mailed to: Pretreatment Manager, DC Water, 5000 Overlook Avenue, S.W., Washington, D.C. 20032 or emailed to pretreatment@dcwater. Call (202) 787‑4177 if you have questions.

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| **Part 1. General Information** | | | | | |
| Facility Name |  | | | | |
| Address |  | | Mailing Address (*if different from previous*) | |  |
| Signing Official |  | | Primary Contact | |  |
| Phone Number |  | | Phone Number | |  |
| Type of health care facility (please check ALL that apply): | | | | | |
| 🞎 Hospital | | 🞎 Pharmacy | | 🞎 Radiology | |
| 🞎 Clinic | | 🞎 Dental | | 🞎 Chemotherapy | |
| 🞎 Laboratory (Pathology/Histology) | | 🞎 Dialysis | | 🞎 Other, list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 🞎 Research and Development | | 🞎 Morgue | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **Part 2. Pollution Prevention and Source Control** | | | | | |
| Does your facility have a Pollution Prevention (P2) Program? | | 🞎 Yes | | 🞎 No | |
| Briefly describe your goals, objectives and accomplishments of your P2 Program and/or Activities. | | | | | |
| Provide a list of all chemicals or categories of chemicals that are collected and disposed as hazardous waste at your Facility. | | | | | |
| Has your facility conducted a **Mercury** inventory? | | 🞎 Yes | | 🞎 No | |
| Areas where Mercury is used (please check ALL that apply): | | | | | |
| 🞎 Thermometers | 🞎 Sphygmomanometers | | 🞎 Gastrointestinal diagnostic equipment | | |
| 🞎 Dilators | 🞎 Feeding tubes | | 🞎 Thermostats | | |
| 🞎 Dental Clinic (amalgam) | 🞎 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| *Chemicals*:   🞎 Zenker’s solution 🞎 Histological fixatives 🞎 Other (specify or attach list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | | | | | |
| *Staining solution and preservatives*:   🞎 Mercury chloride 🞎 Mercury (II) oxide 🞎 Mercury (II) chloride   🞎 Mercury (II) sulfate 🞎 Mercury nitrate 🞎 Mercury iodide 🞎 Other (specify or attach list \_\_\_\_\_\_\_\_\_) | | | | | |
| *Lamps*:   🞎 Fluorescent 🞎 Metal halide 🞎 High pressure sodium 🞎 Ultraviolet | | | | | |
| *Equipment and Batteries*:   🞎 Barometers 🞎 Switches (relay, tilt, silent) 🞎 Mercuric oxide batteries 🞎 Button batteries | | | | | |
| *Other known sources of Mercury:*  🞎 Specify or attach list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Has your Dental Clinic installed an amalgam separator\*? | | 🞎 Yes | | 🞎 No | 🞎 Not Required/NA |
| Has your Dental Clinic submitted a One-Time Compliance Report? | | 🞎 Yes | | 🞎 No | 🞎 Not Required/NA |

\*Amalgam separator required if Dental Clinic uses amalgam and/or removes amalgam fillings, except in emergencies (limited to 9 per year).

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| **Part 3. Discharge Practices** | | | | | |
| A. **Solvents and Alcohols** used (check ALL that apply): | | | | | |
| Solvent/alcohol | *Disposal method****\**** | Solvent/alcohol | *Disposal method****\**** | Solvent/alcohol | *Disposal method****\**** |
| 🞎 Ethanol |  | 🞎 Xylene |  | 🞎 Acetone |  |
| 🞎 Methanol |  | 🞎 Toluene |  | 🞎 Methylene chloride |  |
| 🞎 Isopropanol |  | 🞎 Freon |  | 🞎 Trichloroethylene |  |
| 🞎 Choloroform |  | 🞎 Trichloromethane |  | 🞎 Hexane |  |
| 🞎 Other s, list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| B. **Aldehydes** used (check ALL that apply): | | | | | |
| Solvent/alcohol | *Disposal method****\**** | Solvent/alcohol | *Disposal method****\**** | Solvent/alcohol | *Disposal method****\**** |
| 🞎 **Formaldehyde** |  | 🞎 **Gluteraldehyde** |  | 🞎 **Orthophthaldehyde** (e.g., Cidex OPA) |  |
| ***\* Disposal method: C = contained for off-site disposal*** D = discharged to sanitary sewer (untreated) ***T/R = treated and discharged or recycled*** | | | | | |

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| C. Does your facility discharge **silver/photographic chemicals**? | | 🞎 Yes | 🞎 No |
| If yes, list location(s) and Silver Recovery Unit (SRU) make/model: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| *Identify contractor used to maintain SRU(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | |
| *Identify frequency of maintenance and date of last service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | |
| D. Does your facility discharge **radionuclides** in accordance with an NRC permit?  \*if yes, attach last annual NRC report documenting discharges to sanitary | | 🞎 Yes \* | 🞎 No |
| *If yes, is the waste held prior to discharge?* | | 🞎 Yes | 🞎 No |
| If yes, how long is the waste held? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| E. Does your facility have a **decontamination** **shower**? | | 🞎 Yes | 🞎 No |
| *If yes, what type, how many shower heads, and what capacity containment?* | | | |
| 🞎 Connected to sanitary with NO containment  (# shower heads \_\_\_\_\_\_\_\_) | 🞎 Portable with NO containment  (# of shower heads: \_\_\_\_\_\_\_) | | |
| 🞎 Connected to sanitary with containment  (# shower heads \_\_\_\_\_\_; capacity of containment \_\_\_\_\_\_\_) | 🞎 Portable with containment (# shower heads \_\_\_\_\_\_; capacity of containment \_\_\_\_\_\_\_) | | |
| F. How does your facility dispose of expired and unused/waste **pharmaceuticals**? | | | |

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| **Part 4. Certification (*to be completed by Signing Official for the company*)** | | |
| I certify, under penalty of law, that I have personally examined and familiar with the above information, and that based on my inquiry of those individuals immediately responsible for obtaining the information I believe that the submitted information is true, accurate and complete. | | |
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| Name (print) |  | Title (print) |
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| Signature |  | Date |