DENTAL AMALGAM SEPARATOR APPLICATION

NAME OF BUSINESS: _____

ADDRESS: _____

PHONE NO.: _____ TAX LOT NO. _____

CONTACT PERSON: _____ PHONE NO.: _____

ADDRESS: _____
(if different than above)

OWNER / LESSEE (circle one)

PROPOSED SEPARATOR MANUFACURER/MODEL: _____
NOTE: Amalgam Separator shall be certified to ISO 11143 Standards

DENTAL FACILITY AMALGAM WASTEWATER FLOW RATE: _____ GPM

LOCATION: FRONT/REAR FIRST FLOOR/BASEMENT

PROVIDE PLUMBING AND SITE PLANS THAT INDICATE PROPOSED LAYOUT.

NUMBER OF DENTAL CHAIRS: _____

DAYS/WEEK OPEN: _____ HOURS: _____

PROPOSED INSTALLATION DATE: _____

COMMENTS: _____

_____

_____

PREPARED BY: _____ DATE: _____

SUBMIT APPLICATION, FEE, SEPARATOR DATA, AND SUPPORTING DOCUMENTATION TO:

Oyster Bay Sewer District
15 Bay Avenue
Oyster Bay, NY 11771-1506