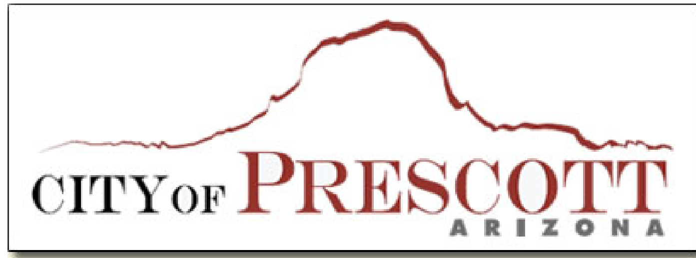

City of Prescott Sewer Usage Questionnaire

Please complete the following information regarding your business. Red asterisks indicate questions that must be answered.

* 1. **Facility Name:**

____

* 2. **Facility Physical Address:**

Street: ____

City: ____

State: ____

Zip Code: ____

* 3. **Owner Mailing Address:**

Street: ____

City: ____

State: ____

Zip Code: ____

4. **Tenant Mailing Address (if applicable):**

Street: ____

City: ____

State: ____

Zip Code: ____

* 5. **Facility Phone Number (including area code):**

(XXX) XXX-XXXX

____

* 6. **Person authorized to represent the facility with official dealings with the City of Prescott:**

Name: ____

Title: ____

Phone Number (including area code): (XXX) XXX-XXXX ______________________________

* 7. **Email address:**

____

Please complete the following information regarding your business. Red asterisks indicate questions that must be answered.

* 8. **What category below best describes the facility?**

- ❍ Industrial/Manufacturing (Examples: electroplating, pharmaceuticals, paint & ink manufacturing, chemical manufacturing, iron & steel, mining)
- ❍ Medical Services (Examples: hospitals, urgent cares, medical offices, dental offices, long-term care facilities, veterinary clinics/hospitals)
- ❍ Food Services (Examples: restaurants, educational facilities, grocery stores, delis, coffee shops)
- ❍ Vehicle Services (Examples: vehicle repair facilities, vehicle maintenance facilities, tire shops, car washes)
- ❍ Waste Hauling
- ❍ Dry Cleaning
- ❍ None of the above

* 9. **What type of waste(s) does the facility generate?**

(Check all that apply)

- ❑ Sanitary wastewater (i.e., restrooms, showers)
- ❑ Non-sanitary wastewater (i.e., discharges to the sewer that differ in quality or quantity from ordinary residential households)
- ❑ Waste containing metals
- ❑ Waste containing chemicals and/or solvents
- ❑ Medical waste
- ❑ Fats, oils, and/or greases (i.e., restaurants)
- ❑ Sand, grit, and/or gravel
- ❑ Detergents and/or cleaners
- ❑ Septage, RV waste, and/or other pumped waste
- ❑ Storwater run-off
- ❑ Facility or equipment washdown
- ❑ Other (please describe below):

____

* 10. **Where are waste(s) disposed of?**

(Check all that apply)

- ❑ Sanitary sewer
- ❑ Stormwater sewer
- ❑ Waste haulers
- ❑ Evaporation
- ❑ Other (please describe below):

____

* 11. **Does the facility have pretreatment devices or on-site treatment processes for wastewater? (i.e., grease trap, grease interceptor, oil/water separator, chemical precipitation)**

- ❍ Unsure
- ❍ No
- ❍ Yes (please describe type, size and location):

Please complete the following information regarding your business. Red asterisks indicate questions that must be answered.

* 12. **Indicate the type of facility:**

(Check all that apply)

- ❑ Hospital
- ❑ Urgent Care
- ❑ Medical Office
- ❑ Dental Office
- ❑ Long-Term Care
- ❑ Laboratory
- ❑ Veterinary Clinic
- ❑ Animal Hospital
- ❑ Other (please describe below):

____

13. **Does the facility conduct medical imaging?**

❍ Yes ❍ No

14. **How does the facility dispose of the following medical wastes:**

Sharps (i.e., needles, glass) ____________________________________

Medications ____________________________________

Expired Medications ____________________________________

Liquid Biohazards (i.e., blood) ____________________________________

Radioactive Material ____________________________________

Other ____________________________________

15. **Does the facility have a medical waste disposal contractor?**

❍ No

❍ Yes. Contractor name and phone number:

____

Please complete the following information regarding your business. Red asterisks indicate questions that must be answered.

16. **Provide the number of operating days per year:**

Average ________________________________

Maximum ________________________________

17. **Provide the total number of employees at the facility per day:**

Average ________________________________

Maximum ________________________________

18. **Provide the number of patients at the facility per day:**

Average ________________________________

Maximum ________________________________

19. **Provide the following information:**

Number of restorative chairs ________________________________

Number of hygiene-only chairs ________________________________

Number of cuspidors ________________________________

Type of vacuum pump ________________________________

Vacuum pump manufacturer ________________________________

Vacuum pump make and model ________________________________

Average number of Amalgam fillings placed each week ________________________________

Average number of Amalgam fillings removed each week ________________________________

20. **Provide the following information on liquid wastes:**

	Means of disposal (i.e., sewer, waste contractor)	**Quantity discharged (i.e., gallons, grams)**	**Frequency (i.e., per day, per month)**
Scrap amalgam	__	__	__
Used fixer	__	__	__
Used chair-side trap	__	__	__
Used vacuum pump screen/filters	__	__	__
Chemical sterilizing solutions	__	__	__

Please complete the following information regarding your business. Red asterisks indicate questions that must be answered.

21. **Is there laundry service at the facility?**

❍ Yes ❍ No

* 22. **Is there a kitchen at the facility?**

(If NO, you do not need to answer any more questions on this page. Click 'Next')

❍ Yes ❍ No

23. **Indicate the hours the facility is open and the typical number of meals served:**

	Hours of Operation	Typical Number of Meals Served
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

24. **Indicate which fixtures are in the kitchen and if they are plumbed to a grease trap or interceptor:**

	Number in Kitchen	Plumbed to grease trap or interceptor? (Y/N)
Dishwasher		
Pot sinks		
Multi-compartment sink		
Mop sink		
Floor drain		
Food steamer		
Food grinder/pulper		
Steam kettle		
Can washer		

25. **Have you observed any problems in the kitchen, such as a slow-running drain or an overflow?**

❍ No

❍ Yes. Please Describe:

____

Please complete the following information regarding your business. Red asterisks indicate questions that must be answered.

* 26. **Does the facility have pretreatment equipment?**

- ☐ No
- ☐ Unsure
- ☐ Yes - grease trap
- ☐ Yes - grease interceptor
- ☐ Yes - other (please describe below):

  ____

27. **Provide the following details on pretreatment equipment (if applicable):**

Number of units:	____________________
Size(s) (in gallons):	____________________
Location(s):	____________________
How often is the unit(s) serviced (i.e., pumped out/cleaned)?	____________________
What company services the unit(s)?	____________________
Does management observe servicing of the unit(s)?	____________________
Does servicing entail complete cleaning of the unit(s), not just removing the grease layer?	____________________
Is the unit(s) refilled with clean water?	____________________
Is there a maintenance log available for the unit(s)?	____________________

Please complete the following information regarding your business. Red asterisks indicate questions that must be answered.

* 28. **Does the facility collect medical waste, used fat, oil, or grease in storage bins?**

(If NO, you do not need to answer any more questions on this page. Click 'Next')

❍ Yes ❍ No

29. **Are storage bins placed outside?**

❍ Yes ❍ No

30. **Are storage bins kept covered?**

❍ Yes ❍ No

31. **Are storage bins located away from storm drains?**

❍ Yes ❍ No

32. **Are storage bins checked for leaks?**

❍ Yes ❍ No

* 33. **Please read the following statement carefully.**

By entering your name and date below, you certify that you have read the statement and agree with its content.

I certify under penalty of law that I have personally examined and am familiar with the information submitted in this document. Based upon my inquiry of those individuals immediately responsible for obtaining the information reported herein, I believe that the submitted information is true, accurate and complete. I am aware that there are penalties for submitting false information.

Name: ______________________________

Date: ______________________________