

CROSS CONNECTION CONTROL SURVEY FORM

APPENDIX "B" DENTAL OFFICE

Date



FACILITY ADDRESS:			Facility ID#:
TYPE OF HAZARD AND LOCATION		PROTECTION: SIZE/TYPE/SERIAL NUMBER	REQUIRED UPGRADE
Dental vacuum pump	Yes No	Degree of Hazard: Severe	Protection: Note: AVB not sufficient protection
Dental Delivery System (water supply)	Yes No	Degree of Hazard: Minor	Protection: No protection required
Cuspidor	Yes No	Degree of Hazard: Severe	Protection: Note: Direct water fed only Air Gap Other
X-Ray Equipment	Yes No	Degree of Hazard: Severe	Protection: Note: Water fed X-ray machines only Air Gap Other
Model Trimmer	Yes No	Degree of Hazard: Moderate	Protection: Air Gap Other
	Yes No	Degree of Hazard:	Protection:
	Yes No	Degree of Hazard:	Protection: