

CROSS CONNECTION CONTROL SURVEY FORM

APPENDIX "B" DENTAL OFFICE



Date / /
(M/D/Y)

*FACILITY ADDRESS:

TYPE OF HAZARD AND LOCATION			PROTECTION: SIZE/TYPE/SERIAL NUMBER/REQUIRED UPGRADE
Dental vacuum pump	Yes <input type="checkbox"/> No <input type="checkbox"/>	Degree of Hazard: Severe	Protection: Note: AVB not sufficient protection
Dental Delivery System (water supply)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Degree of Hazard: Minor	Protection: No protection required
Cuspidor	Yes <input type="checkbox"/> No <input type="checkbox"/>	Degree of Hazard: Severe	Protection: Air Gap <input type="checkbox"/> Other
X-Ray Equipment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Degree of Hazard: Severe	Protection: Air Gap <input type="checkbox"/> Other
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Degree of Hazard:	Protection:
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Degree of Hazard:	Protection:
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Degree of Hazard:	Protection: