

**CROSS CONNECTION CONTROL SURVEY FORM
APPENDIX B**



APPENDIX B: Dental Office

List cross connections that are in addition to the General Form

Date: _____

Facility ID: _____

Facility address, including unit number: _____

Hazards (indicate all that are present)

Dental vacuum pump (Note: AVB protection not sufficient)

Number: _____ Location(s): _____

Degree of hazard: SEVERE

Protection size, type, and serial number: _____

Required Upgrade: _____

Dental delivery system (water supply)

Number: _____ Location(s): _____

Degree of hazard: MINOR

Protection size, type, and serial number: Protection not required.

Required Upgrade: Protection not required.

Cuspidor (direct water-fed only)

Number: _____ Location(s): _____

Degree of hazard: SEVERE

Protection size, type, and serial number: _____

Air Gap

Other

Required Upgrade: _____

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Water fed x-ray equipment

Number: _____ Location(s): _____

Degree of hazard: SEVERE

Protection size, type, and serial number: _____

Air Gap

Other

Required Upgrade: _____

Model trimmer

Number: _____ Location(s): _____

Degree of hazard: MODERATE

Protection size, type, and serial number: _____

Air Gap

Other

Required Upgrade: _____

Other (specify): _____

Number: _____ Location(s): _____

Degree of hazard:

Minor

Moderate

Severe

Protection size, type, and serial number: _____

Required Upgrade: _____