REQUEST FOR RECYCLING OF AMALGAM CANISTER
DECLARATION FORM

Purchase Order#___________
If applicable (Please attach copy)

DENTAL OFFICE or DOCTOR'S NAME ____________________

OFFICE CONTACT NAME ____________ (first) ____________ (last)

OFFICE ADDRESS ____________________ SUITE ________

CITY ____________ PROVINCE ________ POSTAL CODE ________

PHONE ____________

PREFERRED COMMUNICATION

FAX ____________ ☐ SERIAL NUMBER ____________

EMAIL ____________ ☐ MODEL NUMBER ____________

BUSINESS HOURS:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

* Please specify if office is closed during lunch hours and provide details:

CERTIFICATE REQUIRED	YES ☐	NO ☐

DENTAL FIX • 1287 MATHESON BLVD. EAST, MISSISSAUGA, ON L4W 1R1

TECH NAME ____________________ TECH'S PHONE ____________

TO BE PICKED UP AT: DENTAL FIX OFFICE ☐ THE CUSTOMER'S OFFICE ☐

Please fax completed form to 1-888-814-9838

Once the form is received and payment information confirmed, we will fax you back a completed shipping document to affix to the box and will have a courier company collect the packaged materials at your facility.

----- One form per canister -----

I hereby confirm that all the waste materials are packaged securely for public roadway transportation.

DATE : ____________ SIGNATURE : ____________________

Dental Fix
1287 Matheson Blvd. East, Mississauga, ON L4W 1R1
1-866-740-8829
info@dentalfix.ca