

WATERLINE TESTING LOG

Practice Name: _____ Practice Address: _____ City, State & Zip: _____

Treatment: _____ Shock Treatment: _____ Shock Protocol Frequency: _____

Sampling Date	Team Member	Location (Room/Chair/Operatory)	Device	Date of Results	Pass Or Fail	Safety Level (Check One)	Corrective Action (If Necessary)
1/1/2019	Jane Doe	Operatory 1	<input checked="" type="checkbox"/> AW Syringe <input type="checkbox"/> Source Water <input type="checkbox"/> Scaler <input type="checkbox"/> Handpiece <input type="checkbox"/> Combined	1.3.2019	FAIL	● ● ●	Shock (1/4/2019) - Retest (1/5/2019)
1/5/2019	Jane Doe	Operatory 1	<input checked="" type="checkbox"/> AW Syringe <input type="checkbox"/> Source Water <input type="checkbox"/> Scaler <input type="checkbox"/> Handpiece <input type="checkbox"/> Combined	1.7.2019	PASS	● ● ●	Continue Protocol
			<input type="checkbox"/> AW Syringe <input type="checkbox"/> Source Water <input type="checkbox"/> Scaler <input type="checkbox"/> Handpiece <input type="checkbox"/> Combined			● ● ●	
			<input type="checkbox"/> AW Syringe <input type="checkbox"/> Source Water <input type="checkbox"/> Scaler <input type="checkbox"/> Handpiece <input type="checkbox"/> Combined			● ● ●	
			<input type="checkbox"/> AW Syringe <input type="checkbox"/> Source Water <input type="checkbox"/> Scaler <input type="checkbox"/> Handpiece <input type="checkbox"/> Combined			● ● ●	
			<input type="checkbox"/> AW Syringe <input type="checkbox"/> Source Water <input type="checkbox"/> Scaler <input type="checkbox"/> Handpiece <input type="checkbox"/> Combined			● ● ●	
			<input type="checkbox"/> AW Syringe <input type="checkbox"/> Source Water <input type="checkbox"/> Scaler <input type="checkbox"/> Handpiece <input type="checkbox"/> Combined			● ● ●	
			<input type="checkbox"/> AW Syringe <input type="checkbox"/> Source Water <input type="checkbox"/> Scaler <input type="checkbox"/> Handpiece <input type="checkbox"/> Combined			● ● ●	
			<input type="checkbox"/> AW Syringe <input type="checkbox"/> Source Water <input type="checkbox"/> Scaler <input type="checkbox"/> Handpiece <input type="checkbox"/> Combined			● ● ●	
			<input type="checkbox"/> AW Syringe <input type="checkbox"/> Source Water <input type="checkbox"/> Scaler <input type="checkbox"/> Handpiece <input type="checkbox"/> Combined			● ● ●	
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			<input type="checkbox"/> AW Syringe <input type="checkbox"/> Source Water <input type="checkbox"/> Scaler <input type="checkbox"/> Handpiece <input type="checkbox"/> Combined			● ● ●	
			<input type="checkbox"/> AW Syringe <input type="checkbox"/> Source Water <input type="checkbox"/> Scaler <input type="checkbox"/> Handpiece <input type="checkbox"/> Combined			● ● ●	