QuickPass®
IN-OFFICE DENTAL WATER TEST

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	☒ AW Syringe ☐ Source Water ☐ Scaler ☐ Handpiece ☐ Combined	1.3.2019	FAIL	● ● X	Shock(1/4/2019)-Retest(1/5/2019)
1/5/2019	Jane Doe	Operatory 1	☒ AW Syringe ☐ Source Water ☐ Scaler ☐ Handpiece ☐ Combined	1.7.2019	PASS	X ● ●	Continue Protocol
			☐ AW Syringe ☐ Source Water ☐ Scaler ☐ Handpiece ☐ Combined			● ● ●	
			☐ AW Syringe ☐ Source Water ☐ Scaler ☐ Handpiece ☐ Combined			● ● ●	
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