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)
			☐ AW Syringe ☐ Source Water ☐ Scaler ☐ Handpiece ☐ Combined				
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