

Section III – Medical Waste Tracking:

Waste Generation:

		Type of Waste Generated			
Sharps		Non Sharps			
	Hypodermic needles		Human tissue, surgery specimen		Vaccines
	Syringes		Autopsy specimen		Animal parts, tissue, or fluids
	Needles with tubing		Pharmaceuticals		Contaminated animal bedding
	Broken glass		Chemotherapeutic waste		Other:
	Scissors		Isolation waste		
	Razors/ Scalpel Blades		Human blood & blood products		
	Pipettes		Cultures and stocks		
Total Amount of Waste, by Weight, in pounds, Generated in a 30-day					

All infectious medical waste shall be handled within the facility in accordance with the generator's written medical waste management plan to include contingency measures.

Medical waste does not include: a) Paper products, paper towels, materials containing non-fluid blood or other solid waste products that are usually generated by medical facilities and which are not bio-hazardous. b) Household waste, including home-generated medical sharps, radioactive waste and hazardous waste, as defined by 40 CFR Part 261.3. c) Any waste normally generated on a farm or ranch during agricultural, veterinary, or livestock management activities. d) Human secretions or excretions that do not contain fluid blood.

Method of Removal:

Indicate where medical waste will be taken for treatment or further storage. (Check one):

By Applicant to off-site facility:

Name of Facility: _____

Address: _____

(Provide the physical address of the facility where medical waste will be shipped.)

By off-site transporter:

Company Name: _____

Address: _____

(Provide the physical address of transporter)

Receiving Facility: _____

Address: _____

(Provide the physical address of facility to which medical waste will be shipped.)

The information contained in this application, which serves as a basis for permitting is, to the best of my knowledge, true and correct. I understand that any misrepresentation of the facts in this application, or failure to comply with sanitary standards, is grounds for denial, administrative fine or revocation of the infectious medical waste permit.

Signature of Authorized Representative Name of Authorized Representative (Print or type.) Date

Do Not Write in This Box FOR OFFICIAL USE ONLY	
Date Received _____	Permit No. issued _____
Date Issued _____	Receipt No. _____