



STANISLAUS COUNTY DEPARTMENT OF ENVIRONMENTAL RESOURCES

3800 Cornucopia Way, Suite C Modesto, CA 95358-9492

Phone: 209.525.6700 Fax: 209.525.6774

INFORMATION PACKET FOR MEDICAL WASTE GENERATORS

The Medical Waste Management Act defines medical waste as material that is Bio-hazardous or Sharps waste, or waste resulting from immunization or search on humans and animals. This packet contains the information and forms you will need to help you comply with the Medical Waste Management Act, California Health and Safety Code (Sections 117600-118360).

Reminder: Limited Quantity Hauling Exemption was eliminated on 1/1/2015. Please refer to the following CDPH link for updates:

<https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/Generators.aspx>

Instructions

Please return the completed forms prior to medical waste generation or treatment.

1. Complete the **“Pre-Application Questionnaire”** on Page 2. If your answers indicate you are not required to register as a medical waste generator, then complete the **“Certification Statement”** on Page 4 and return both completed forms to the mailing address below.
2. If you are a medical waste generator, as indicated by the **“Pre-Application Questionnaire”**, you must:
 - A. Complete the **“Registration for Medical Waste”** form located on Page 5.
 - B. Complete a **“Medical Waste Management Plan”** following the guidelines provided on Page 6. If there are no changes to your Management Plan, indicate “No Changes”.
 - C. Return the completed forms and management plan to our Department at the mailing address below within fourteen (14) working days.
 - D. If a permit is required, complete and return the appropriate permit application included in this packet.

Your cooperation in promptly completing these forms is greatly appreciated. If you have any questions regarding registration or handling requirements, please contact our office at (209) 525-6700



PRE-APPLICATION QUESTIONNAIRE Regulated Medical Wastes

Type of Medical Waste Generated (Please check all that apply to your facility):

- ☐ **Laboratory Wastes:** Specimen or microbiologic cultures, stocks of infectious agents, live and attenuated vaccines and culture mediums
- ☐ **Blood or Body Fluids:** Liquid blood elements, other regulated body fluids, articles contaminated with blood or body fluids
- ☐ **Sharps:** Syringes, needles, blades and contaminated broken glass
- ☐ **Contaminated Animals:** Animal carcasses, body parts and bedding materials
- ☐ **Surgical Specimens:** Human or animal parts or tissues removed surgically or by autopsy
- ☐ **Isolation Wastes:** Waste contaminated with excretion, exudates, or secretions from humans or animals who are isolated due only to the highly communicable diseases listed by the Centers for Disease Control, Biosafety Level 4 precautions
- ☐ **Pharmaceuticals:** Any drug, including over-the-counter medication, which has no value, (i.e. cannot be dispensed, repacked, sold, restricted, or returned for credit)

Please **check** the appropriate box for the questions listed below:

1. Does your business or service generate any of the medical waste listed above? ☐ Yes ☐ No

If your answer is "No", please complete the "**Certification Statement**" on Page 4 and return it with this questionnaire to the address indicated. You **do not** need to complete the remainder of this questionnaire.

2. Do you generate less than 200 pounds of medical waste per month? ☐ Yes ☐ No

If you answered "Yes", you are a small generator.



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3. Small quantity generators may store their medical waste in a permitted Common Storage facility with other small generators. ☐ Yes ☐ No
Do you plan to do this at your facility?

If your answer is "Yes", you must fill out a **"Common Storage Facility Permit Application"** on page 10 and complete page 5.

4. Do you plan to treat your medical waste onsite, by autoclaving, incinerating, microwaving, or by another California approved method? ☐ Yes ☐ No

If your answer is "Yes", you **must** complete Pages 5, 6, 7, 8 and 9. Return them with this questionnaire and the appropriate fee to the address indicated on Page 1.

If you do not generate medical waste, then complete the **"Certification Statement"** on Page 4 and return it with this questionnaire to the address provided on Page 1. You do not need to complete the rest of this package.



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CERTIFICATION STATEMENT

**FOR NON-MEDICAL WASTE GENERATORS AND MEDICAL WASTE GENERATORS
NOT REQUIRED TO REGISTER**

Business Name: _____

Business Address: _____

City State Zip Code

Phone Number: (_____)_____-_____

Contact Person: _____

I am not required to register as a Medical Waste Generator because (*Please check all that apply*)

☐ I do not generate any medical waste.

Other: _____

I declare under penalty of law that to the best of my knowledge and belief the statements made herein are true and correct. I hereby consent to all necessary inspections made pursuant to the California Medical Waste Management Act and incidental to the issuance of this registration and the operation of this business.

Signature: _____ Date: _____



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REGISTRATION FOR MEDICAL WASTE GENERATORS

GENERATOR NAME: _____

Generator Facility Address: _____
(City/Zip)

Phone Number: (_____) _____ - _____

Generator Mailing Address: _____
(City/Zip)

Type of Business: _____

Authorized Representative: _____

Title: _____

Email: _____

Emergency Phone Number: (_____) _____ - _____

REGISTRATION FOR:

- ☐ Small Quantity Generator Only (Generates less than 200 lbs/month).
- ☐ Small Quantity Generator with Onsite Treatment (Generates less than 200 lbs/month).
- ☐ Large Quantity Generator Only (Generates 200 lbs or more/month).
- ☐ Large Quantity Generator with Onsite Treatment (Generates 200 lbs or more/month).
- ☐ Common Storage Facility Operation.

I declare under penalty of law that to the best of my knowledge and belief the statements made herein are true and correct. I hereby consent to all necessary inspections made pursuant to the California Medical Waste Management Act and incidental to the issuance of this registration and the operation of this business.

Signature: _____ Date: _____

OFFICIAL USE ONLY

Service Code _____ Date Received _____ Date Approved: _____

Approved by: _____ Date Expired _____



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MEDICAL WASTE MANAGEMENT PLAN

According to the Medical Management Act (Health and Safety Code, Section 117930 and 117960), any Small Quantity Generators (less than 200 pounds per month) that provide Onsite Treatment and all Large Quantity Generators (greater than 200 pounds per month) shall have a Medical Waste Management Plan on file with the Stanislaus County Department of Environmental Resources. The Medical Waste Management Plan shall contain the following information as appropriate for your facility:

Business Name: _____

Business Address: _____ (City/Zip)

Phone Number: Phone Number: (_____) _____ - _____

Type of Facility or Business: _____

E-Mail Address: _____

Registration for:

- ☐ Small Quantity Generator Only (Generates less than 200 lbs/month).
- ☐ Small Quantity Generator with Onsite Treatment (Generates less than 200 lbs/month).
- ☐ Large Quantity Generator Only (Generates 200 lbs or more/month).
- ☐ Large Quantity Generator with Onsite Treatment (Generates 200 lbs or more/month).
- ☐ Common Storage Facility Operation

Person responsible for implementation of the Medical Waste Management Plan:

Name: _____

Title: _____ Date: _____

1. List the types of medical waste generated at your facility, i.e., laboratory wastes, blood or body fluids, sharps, contaminated animals, surgical specimens, isolation wastes, or pharmaceuticals: (see **"Regulated Medical Wastes"** listed on Page 2).



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2. Estimate the monthly amount of medical waste generated (including sharps waste) at your facility:

_____ Pounds/month

_____ Pounds/month

3. Describe the medical waste handling procedures utilized by and applicable to your facility, including, but not limited to the following:

- A. Onsite location and method for segregation, containment, packaging, labeling and collection:

- B. Storage area description with storage methods utilized, including duration and temperature controls, if applicable:

- C. Onsite treatment facility description, including type of treatment utilized (i.e. autoclave, incineration, steam sterilization), maximum capacity, time and temperature necessary, alternate contingency plan in case of equipment failure, etc.:

- D. Name, address, registration number and phone number of the registered hazardous waste hauler employed by your facility:

Name: _____

Address: _____ (City/Zip)

Phone: (_____) _____ - _____

Registration #: _____



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- E. Name, address and phone number of Offsite Treatment Facility where medical waste is transported for treatment, if different than hauler:

Name: _____

Address: _____
(City/Zip)

Phone: (_____) _____ - _____

- F. All medical waste generators are required to keep accurate records regarding containment, storage, hauling, treatment and disposal. All medical waste records areas are to be maintained and available for review during inspection for three (3) years.

Do you have tracking documents for all medical wastes ☐ Yes ☐ No
handled at your facility?

- G. Describe (if applicable) how you handle mixed medical waste, hazardous or radioactive wastes?

- H. Describe your medical waste emergency action plan, including procedures for handling spills, exposures, equipment failures, etc...:

I hereby certify under penalty of perjury that this document and all the attachments have been prepared under my direction and supervision to assure that qualified personnel properly gather and evaluate the information submitted. The information is to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibilities of fine and imprisonment.

Signature: _____

Date: _____



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**PERMIT APPLICATION FOR ON-SITE MEDICAL
WASTE TREATMENT**

GENERATOR NAME: _____

Generator **Facility** Address: _____
(City/Zip)

Phone Number: (_____) _____ - _____

Generator **Mailing** Address: _____
(City/Zip)

Type of Business: _____

Authorized Representative: _____

Title: _____

Emergency Phone Number: (_____) _____ - _____

APPLICATION FOR:

- ☐ Small Quantity Generator with Onsite Treatment (Generates less than 200 lbs/month).
- ☐ Large Quantity Generator with Onsite Treatment (Generates 200 lbs or more/month).

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APPLICATION FOR A COMMON STORAGE FACILITY PERMIT

A Common Storage Facility is utilized for the collection of medical waste produced by small quantity generators operating independently, but sharing the same "common" storage area.

Please complete the following:

☐ New ☐ Renewal

FACILITY NAME: _____

BUSINESS ADDRESS: _____

CITY, STATE, ZIP CODE: _____

BUSINESS PHONE: _____

CONTACT PERSON: _____

Common Storage Facility Address: _____

Please list below the names of the other Small Quantity Generators who will share the Common Storage Facility (If more than 5, attach info):

1. _____
2. _____
3. _____
4. _____
5. _____

Applicant's Signature

Date

OFFICIAL USE ONLY

Service Code _____ Date Received _____ Date Approved: _____

Approved by: _____ Date Expired _____