Stanislaus County
Department Of Environmental Resources
3800 Cornucopia Way, Suite C, Modesto, California 95358

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 with Onsite Treatment (generates less than 200 pounds per month).
- ❑ State Licensed Small Quantity Generator (generates less than 200 lbs/month).
- ☐ Large Quantity Generator Only (generates 200 pounds or more per month).
- ☐ Large Quantity Generator with Onsite Treatment (generates 200 pounds or more per month).

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).

   _____

   _____

   _____

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 #: _____

   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 handled at your facility? ☐ Yes ☐ No

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. Attach a facility layout identifying all areas where medical waste is stored and generated. Ensure the document is legible.

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: _____