Stanislaus County
Department Of Environmental Resources

3800 Cornucopia Way, Suite C, Modesto, California 95358

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 required to register as a medical waste generator, as indicated by affirmative answers to questions 4 & 5 on 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

RETURN ALL COMPLETED FORMS TO:

3800 Cornucopia Way, Suite C
Modesto, California 95358-9492
(209) 525-6700
(209) 525-6774 (Fax)

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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 bellow:

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.

3. Are you a state licensed facility and small quantity generator?(i.e. clinical laboratory, primary care clinic, etc.) ☐ Yes ☐ No

   If you ansered "Yes", then you must complete page 5 and the Medical Waste Management Plan starting on page 6.

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

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

5. 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 are not a state licensed small quantity generator **and** your answers to question 4 and 5 are "No", 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.
- ❑ I generate **less** than 200 pounds of medical waste per month **and do not** have a state license.
- ❑ Off-site treatment disposal through a registered hazardous waste hauler/mail-back service.
- ❑ I **do not** treat any medical waste at my facility by means of autoclaving, incinerating or microwaving.

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

State License Type: ________________________________

State License Number: ______________________________

GENERATOR NAME: ____

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

Phone Number: (____________) ____

Generator Mailing Address: ____
(City/Zip)

Type of Business: ____

Authorized Representative: ____

Title: ____

Emergency Phone Number: (___________) ______________________________________

REGISTRATION FOR:

☐ Small Quantity Generator with Onsite Treatment (Generates less than 200 lbs/ month).
☐ State Licensed Small Quantity Generator (Generates less than 200 lbs/month).
    ***Attach Copy of State Issued License for Facility**
☐ 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: _______________

REGISTRATION APPROVAL OFFICIAL USE ONLY

Business I.D. No. ___________________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 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: ____

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PERMIT APPLICATION FOR ON-SITE MEDICAL WASTE TREATMENT

State License Type: ___________________

State License Number: _________________

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).

OFFICIAL USE ONLY

Business I.D. No. ________________Service Code ______ Date Received __________

Date Approved: ___________Approved by: _____________ Date Expired ___________

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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

Business I.D. No. __________________Service Code _______ Date Received ___________

Date Approved: ____________Approved by: ____________ Date Expired ____________