



MEDICAL WASTE AND HAZARDOUS WASTE GENERATOR PERMIT APPLICATION

A. Business Information:

- First-Time Application
 New Owner
 Business Moved
 Change of Information

Facility Name: _____

(Last Name, First Name if individual. Otherwise, corporation, LLC, or partnership name.)

Site Address: _____ City: _____ Zip: _____

Facility Phone No.: (____) _____ Fax No.: (____) _____ Days/Hours of Operation: _____

Contact Person: _____ Contact Phone No.: (____) _____ ext. _____

Owner Name(s): _____
Last Name, First Name if individual(s). Otherwise, corporation, LLC, or partnership name.

Owner Phone No.: (____) _____ Fax No.: (____) _____

Mailing Address: _____ City: _____ State: _____ Zip: _____
If different from site address.

Billing Address: _____ City: _____ State: _____ Zip: _____
If different from mailing address.

Billing Contact: _____ Contact Phone No.: (____) _____ ext. _____
If different from owner.

Principal Type of Business (e.g., dentistry, medical clinic): _____

Owned by Individual
 Partnership
 Corporation or LLC
 Other

EPA ID Number: _____
(If hazardous waste generator.)

B. Certification:

The undersigned hereby applies for a Hazardous Waste Generator Permit and/or Medical Waste Generator Permit from the County of Santa Clara. I hereby certify that the submitted information is true, accurate, and complete. I understand that a new application will be required if this facility changes ownership, moves, or begins generating wastes which are not listed on this application.

Signature of Owner/Operator _____ Title: _____ Date: _____
Agent or Representative: _____

C. Medical Waste Information:

If you generate any of the Regulated Medical Wastes listed on the following page, you must obtain a Medical Waste Generator Permit. You must prepare and submit a Medical Waste Management Plan if you are a Small Quantity Generator who treats medical waste onsite, a Large Quantity Generator, or operate under a Limited Quantity Hauling Exemption. A sample Medical Waste Management Plan is available from our Department. You may use either the format provided or your own format, as long as it complies with the requirements of the Medical Waste Management Act.

Complete the following table by checking the appropriate boxes in the column on the right side.

| Type of Regulated Medical Waste | We Generate This Much Waste Per Month (Peak Month) |
|--|--|
| Laboratory Wastes: Specimen or microbiologic cultures, stocks of infectious agents, live and attenuated vaccines, and culture mediums. | <input type="checkbox"/> We do not generate this waste <input type="checkbox"/> We generate less than 200 pounds per month <input type="checkbox"/> We generate 200 or more pounds per month |
| Blood or Body Fluids: Liquid blood elements or other regulated body fluids, or articles contaminated with blood or body fluids. | <input type="checkbox"/> We do not generate this waste <input type="checkbox"/> We generate less than 200 pounds per month <input type="checkbox"/> We generate 200 or more pounds per month |
| Sharps: Syringes, needles, blades, broken glass. | <input type="checkbox"/> We do not generate this waste <input type="checkbox"/> We generate less than 200 pounds per month <input type="checkbox"/> We generate 200 or more pounds per month |
| Contaminated Animals: Animal carcasses, body parts, bedding materials. | <input type="checkbox"/> We do not generate this waste <input type="checkbox"/> We generate less than 200 pounds per month <input type="checkbox"/> We generate 200 or more pounds per month |
| Surgical Specimens: Human or animal parts or tissues removed surgically or by autopsy. | <input type="checkbox"/> We do not generate this waste <input type="checkbox"/> We generate less than 200 pounds per month <input type="checkbox"/> We generate 200 or more pounds per month |
| Isolation Waste: 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. | <input type="checkbox"/> We do not generate this waste <input type="checkbox"/> We generate less than 200 pounds per month <input type="checkbox"/> We generate 200 or more pounds per month |
| Pharmaceutical Waste: Outdated, unused California-only regulated pharmaceuticals. | <input type="checkbox"/> We do not generate this waste <input type="checkbox"/> We generate less than 200 pounds per month <input type="checkbox"/> We generate 200 or more pounds per month |

Check the box(es) below for the statement(s) that apply to your business or service:

- To the best of my knowledge my facility **does not generate, store, treat, or haul** any Regulated Medical Wastes. *(If you check this box, skip to Section D, below.)*
- My facility is a **Small Quantity Generator (SQG)** because it generates less than 200 pounds per month (peak month) of Regulated Medical Waste. Medical waste is not treated onsite.
- My facility is a **Small Quantity Generator (SQG)** because it generates less than 200 pounds per month (peak month) of Regulated Medical Waste and we wish to apply for a new **Common Storage Facility Permit** which will allow us to accumulate onsite, for collection by a registered hazardous waste hauler, medical waste from onsite SQGs who would otherwise operate independently.
- My facility is a **Small Quantity Generator (SQG)** because it generates less than 200 pounds per month (peak month) of Regulated Medical Waste and we will utilize the following existing permitted **Common Storage Facility**:
 Common Storage Facility Name: _____
 Common Storage Facility Address: _____
- My facility is a **Large Quantity Generator (LQG)** because it generates 200 or more pounds per month (peak month) of Regulated Medical Waste. Medical waste is not treated onsite.
- My facility generates Regulated Medical Waste and treats medical waste on-site as described in the attached Medical Waste Management Plan for the purpose of disposing of the treated waste in the regular garbage.
 The maximum quantity of waste generated per month is: _____ pounds.
- My facility generates less than 20 pounds per week of Regulated Medical Waste and we wish to apply for a **Limited Quantity Hauling Exemption (LQHE) Permit**, which will allow our staff to transport up to 20 pounds of medical waste per trip to a permitted medical waste treatment facility, transfer station, parent organization, or another health care facility for the purpose of consolidation before treatment and disposal.

Untreated Regulated Medical Waste must be transported by a registered hazardous waste hauler. Provide the following information regarding your contracted hauler(s):

| Business Name | Address | Phone No. |
|---------------|---------|-----------|
| | | |
| | | |
| | | |

D. Hazardous Waste Generation Information:

If you generate hazardous waste, you must obtain a Hazardous Waste Generator Permit from the Department of Environmental Health. The annual Hazardous Waste Generator Permit fee is determined by the total quantity of hazardous waste generated per year. [Exception: Permitting and inspection of hazardous waste generators located within the city limits of Gilroy, Sunnyvale, or Santa Clara is done by the local Fire Department. If you are located in one of those cities, contact the Fire Department regarding their permit requirements. Agency contact information is available at www.unidocs.org/members.html.]

Complete the following table by checking the appropriate boxes and filling in the quantity generated for each type of Hazardous Waste, or check the box for the one statement below that is applicable to your facility:

- My facility generates hazardous waste, but is located within the city limits of Gilroy, Sunnyvale or Santa Clara.
- To the best of my knowledge, my facility does not generate any hazardous waste.

| Type of Hazardous Waste ¹ | Do We Generate This Waste On-Site? | We Manage This Waste Using These Treatment/Disposal Method(s) ² <i>(Definitions provided below.)</i> | We Generate This Much Waste Per Year ³ |
|--|---|--|--|
| Spent X-Ray Fixer | <input type="checkbox"/> Yes. <input type="checkbox"/> No. <i>(Skip to next row)</i> | <input type="checkbox"/> Treated on-site. <input type="checkbox"/> Shipped off-site for recycling/treatment/disposal. <input type="checkbox"/> Other: <i>(Specify)</i> | <input type="checkbox"/> gal. <input type="checkbox"/> lbs. |
| Spent cold sterilization solution with glutaraldehyde or ortho-phthalaldehyde (OPA) as the active ingredient | <input type="checkbox"/> Yes. <input type="checkbox"/> No. <i>(Skip to next row)</i> | <input type="checkbox"/> Treated on-site. <input type="checkbox"/> Shipped off-site for recycling/treatment/disposal. <input type="checkbox"/> Other: <i>(Specify)</i> | <input type="checkbox"/> gal. <input type="checkbox"/> lbs. |
| Other spent cold sterilization solution | <input type="checkbox"/> Yes. <input type="checkbox"/> No. <i>(Skip to next row)</i> | <input type="checkbox"/> Treated on-site. <input type="checkbox"/> Shipped off-site for recycling/treatment/disposal. <input type="checkbox"/> Other: <i>(Specify)</i> | <input type="checkbox"/> gal. <input type="checkbox"/> lbs. |
| Waste formalin | <input type="checkbox"/> Yes. <input type="checkbox"/> No. <i>(Skip to next row)</i> | <input type="checkbox"/> Treated on-site. <input type="checkbox"/> Shipped off-site for recycling/treatment/disposal. <input type="checkbox"/> Other: <i>(Specify)</i> | <input type="checkbox"/> gal. <input type="checkbox"/> lbs. |
| Lead foil from x-ray film | <input type="checkbox"/> Yes. <input type="checkbox"/> No. <i>(Skip to next row)</i> | <input type="checkbox"/> Treated on-site. <input type="checkbox"/> Shipped off-site for recycling/treatment/disposal. <input type="checkbox"/> Other: <i>(Specify)</i> | <input type="checkbox"/> gal. <input type="checkbox"/> lbs. |
| Dental amalgam | <input type="checkbox"/> Yes. <input type="checkbox"/> No. <i>(Skip to next row)</i> | <input type="checkbox"/> Treated on-site. <input type="checkbox"/> Shipped off-site for recycling/treatment/disposal. <input type="checkbox"/> Other: <i>(Specify)</i> | <input type="checkbox"/> gal. <input type="checkbox"/> lbs. |
| Other: <i>(Specify)</i> | <input type="checkbox"/> Yes. <input type="checkbox"/> No. <i>(Skip to next row)</i> | <input type="checkbox"/> Treated on-site. <input type="checkbox"/> Shipped off-site for recycling/treatment/disposal. <input type="checkbox"/> Other: <i>(Specify)</i> | <input type="checkbox"/> gal. <input type="checkbox"/> lbs. |

Definitions of Treatment/Disposal Methods

Recycled on-site: The facility takes the waste or any constituent of the waste, treated or not, and reuses it on-site or ships it off-site as an Excluded Recyclable Material.

Treated on-site: The facility employs any method, technique, or process which changes or is designed to change the physical, chemical, or biological character or composition of the hazardous waste or any material contained therein, or removes or reduces its harmful properties or characteristics for any purpose including, but not limited to, energy recovery, material recovery, or reduction in

¹ Do not list medical (i.e., red bag) wastes in this section.

² Depending on how a waste or its constituents are recycled and/or treated, more than one treatment/disposal category may apply. All applicable boxes in column 3 of the waste inventory table must be checked.

³ Solids must be reported in pounds. Liquids may be reported in either pounds or gallons. Enter zero for wastes recycled on-site.

volume (e.g., pH adjustment, evaporation, precipitation, filtration, distillation, compacting, etc.). If, after treatment, the material is reused at the facility, the "Recycled on-site" box in the waste inventory table should be checked.

Shipped off-site for recycling/treatment/disposal: The facility sends the waste, or any hazardous treatment residual, to an off-site permitted treatment, storage, or disposal facility (TSDF).

Additional information regarding hazardous waste management can be found at www.dtsc.ca.gov and www.EHinfo.org/hazmat.

Agency Use Only

STAFF

Business Code:

- 01-Corporation; 02-Individual; 03-Partnership;
 04-Local Agency; 05-County Agency; 06-State Agency;
 07-Federal Agency; 99-Unknown

City Code:

- 01-Palo Alto; 02-Los Altos; 03-Los Altos Hills;
 04-Mountain View; 05-Cupertino; 06-Sunnyvale;
 07-Santa Clara; 08-Milpitas; 09-Campbell;
 10-Saratoga; 11-Los Gatos; 12-Monte Sereno;
 13-San Jose; 14-Morgan Hill; 15-Gilroy;
 16-Unincorporated; 19-Stanford; 20-San Martin;
 21-Moffett Field

Business Type:

- 04-HazWaste Only; 07-MedWaste Only; 10-Multi-program

Inspector Employee ID: _____

Program Element (PE): _____

Permit Status:

- 21-Full, Ongoing Permit; 14-Billed by County Fire
 15-Billed by Mountain View 16-Billed by Milpitas
 17-Billed by Palo Alto 18-Billed by San Jose

Type of Permit:

- P-Permanent; PE-Permanent Exempt

Current Status:

- 01-Active; 04-Active, exempt from billing

Mail Correspondence To:

- 01-Owner; 02-Facility

Create Special Program Records:

- 2599-General Storage Program Record - No Fee

Create Surcharge Records:

- 5001-State Hazardous Materials Service Fee

SUPPORT STAFF

Owner ID: _____

Multiple Owner ID: _____

Multiple Owner ID: _____

Facility ID: _____

Program Record ID: _____

Program Record ID: _____

Program Record ID: _____

Permit Record ID: _____

Permit Record ID: _____

Permit Record ID: _____

Account Record ID: _____

Comments:

Prepared by (MW): _____ **Date:** _____

Prepared by (HM): _____ **Date:** _____

Senior/Manager Initials: _____ **Date:** _____ **Input by:** _____ **Date:** _____

MEDICAL WASTE MANAGEMENT PLAN

*For Use by Generators of Regulated Medical Waste Located in Santa Clara County
Authority Cited: California Health and Safety Code (HSC) Sections 117935 & 117960*

This format for a Medical Waste Management Plan has been developed by the Santa Clara County Department of Environmental Health, Division of Hazardous Materials Compliance and Solid Waste Enforcement, Medical Waste Management Program. You do not need to use this document. If you wish to use your own format, it must conform to the requirements of the Medical Waste Management Act. Medical waste generators must maintain accurate records relative to the storage, hauling, treatment and disposal of medical waste onsite at each permitted facility for a minimum of three years. If you have questions, please call (408) 918-3400 and ask for the Medical Waste Management Program.

A. Facility Information:

Facility Name: _____

Address: _____ City: _____ Zip: _____

Type of Business: _____

Name of Person Responsible for implementation of plan: _____

Title: _____ Phone No.: (____) _____ ext. _____

B. Types of Medical Waste Generated:

We generate the following types of Regulated Medical Waste: *(Check all boxes that apply)*

- Laboratory Wastes:** Specimen or microbiologic cultures, stocks of infectious agents, live and attenuated vaccines, and culture mediums.
- Blood or Body Fluids:** Liquid blood elements or other regulated body fluids, or articles contaminated with blood or body fluids.
- Sharps:** Syringes, needles, blades, broken glass.
- Contaminated Animals:** Animal carcasses, body parts, bedding materials.
- Surgical Specimens:** Human or animal parts or tissues removed surgically or by autopsy.
- Isolation Waste:** 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.
- Pharmaceutical Waste:** Outdated, unused California-only regulated pharmaceuticals.

C. Quantity of Regulated Medical Waste Generated:

We generate this much medical waste (peak month): _____ pounds per month.

- We are a: Small Quantity Generator (SQG) because we generate less than 200 pounds per month (peak); or
 Large Quantity Generator (LQG) because we generate 200 pounds or more per month (peak).

D. Medical Waste Storage:

- ❖ Is this facility a Common Storage Facility that accumulates onsite, for collection by a registered hazardous waste hauler, medical waste from onsite Small Quantity Generators (SQG) who would otherwise operate independently?
 Yes; No.

If “Yes,” complete the following information for each SQG that uses this Common Storage Facility (attach additional pages if needed):

| | Business Name | Address |
|----|---------------|---------|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |
| 6 | | |
| 7 | | |
| 8 | | |
| 9 | | |
| 10 | | |
| 11 | | |
| 12 | | |
| 13 | | |
| 14 | | |
| 15 | | |
| 16 | | |
| 17 | | |
| 18 | | |
| 19 | | |
| 20 | | |

- ❖ Does this facility accept home-generated sharps waste, to be consolidated with the facility’s medical waste stream?
 Yes; No.

If “Yes,” the generator of the sharps waste, a member of the generator’s family, or a person authorized by Santa Clara County Department of Environmental Health must transport the waste to this facility and the sharps waste must be accepted at a central location at this facility.

E. On-Site⁴ Medical Waste Treatment:

- ❖ Does this facility treat medical waste on-site? Yes; No.

If “Yes,” what treatment method(s) are utilized?

- Incineration;
- Steam sterilization;
- Microwave technology;
- Other approved alternative treatment. (*Specify*): _____

Skip to Section F if this facility is a Small Quantity Generator.

- ❖ This facility’s total onsite medical waste treatment capacity is: _____ pounds per hour.

⁴ Onsite means at your facility or a Common Storage Facility or other location within 400 yards of your facility’s property line.

F. Medical Waste Transportation and Disposal:

- ❖ Does this facility accept medical waste generated offsite?⁵ Yes; No.
- ❖ Provide the following information regarding any offsite treatment and disposal facilities to which untreated Regulated Medical Waste is shipped:

| Business Name | Address |
|---------------|---------|
| | |
| | |
| | |
| | |

- ❖ Provide the following information about the registered hazardous waste hauler that will be used to remove for treatment any untreated medical waste and/or medical waste for which onsite medical waste treatment methods are not appropriate due to the hazardous or radioactive characteristics of the waste:

Hauler Business Name: _____

Address: _____

- ❖ Does this facility haul Regulated Medical Waste under a Limited Quantity Hauling Exemption (LQHE) permit pursuant to Health and Safety Code Section 118030?⁶ Yes; No.

If “Yes,” provide the following information regarding the destination treatment and disposal facilities to which the waste is hauled:

| Business Name | Address |
|---------------|---------|
| | |
| | |
| | |
| | |

- ❖ Is this facility located on rental or leased property where the building management provides for registered hazardous waste hauler service for medical waste transportation to which the building tenants may subscribe or are required to subscribe? Yes; No.

If “Yes,” provide the following information regarding the registered hauler:

Hauler Business Name: _____

Address: _____

⁵ Offsite means any location that is not onsite.

⁶ To qualify for a LQHE permit, a facility must generate less than 20 pounds per week of Regulated Medical Waste and haul no more than 20 pounds of medical waste per trip to a permitted medical waste treatment facility, transfer station, parent organization, or another healthcare facility for the purpose of consolidation before treatment and disposal.

G. Emergency Action Plan: *(Large Quantity Generators are required to have an Emergency Action Plan. While not mandatory for Small Quantity Generators, it is recommended that SQGs complete this section as a good management practice.)*

❖ In the event of failure of this Medical Waste Management Plan (e.g., medical waste hauler is unable to pick up medical waste at the designated time) what alternative method(s) of treatment and/or disposal of medical waste will be used?

We will call another registered hazardous waste hauler for pickup; or

We will do the following: _____

❖ Describe, in detail, how this facility manages medical waste spills (e.g., gloves, mask, gown, disinfectant):

❖ Describe, in detail, how this facility handles, treats, and disposes of liquid/semi-liquid laboratory waste:

H. Certification:

I hereby certify that the information provided in this plan is complete and accurate.

Signature: _____ Date: _____

Title: _____ Phone No.: () _____ ext. _____