

**NEW JERSEY REGULATED MEDICAL WASTE  
COMMERCIAL COLLECTION FACILITY ANNUAL REPORT**

**NEW JERSEY DEPARTMENT OF ENVIRONMENTAL PROTECTION**

Solid and Hazardous Waste Management Program  
Bureau of Landfill and Hazardous Waste Permitting  
(609) 984-6985

**I. COMMERCIAL COLLECTION FACILITY IDENTIFICATION INFORMATION**

<b>1. Reporting period</b> July 1, 2008 through June 30, 2009		<b>Due</b> July 30, 2009
<b>2. Facility Name and Mailing Address</b>  _____ Name  _____ Address  _____ City, State & Zip Co		<b>3. NJDEP Facility Identification Number</b>  _____
<b>4. Contact Person</b>		
_____		(____) _____
Name (Please Print)	Title	Telephone Number
<b>5. Certification</b>		
I certify that I have personally examined and am familiar with the information submitted in this and all attached documents, and based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate and complete.		
Name and official title of owner or owner's authorized representative  _____		
Signature	Title	Date

**II. DISPOSITION INFORMATION**

<b>6. Total Quantity of Regulated Medical Waste by Category and Destination</b>		
	Transporter, Transfer Facility or Transfer Station	Intermediate Handler or Destination facility
A. Untreated Waste (pounds)		
B. Treated Waste (pounds)		

### III. GENERATOR IDENTIFICATION

**7. Total Number of Generators From Whom Regulated Medical Waste was Directly Accepted via self-transport \_\_\_\_\_.** (If your answer is "0", skip this Section)

**8. Identity of Generators**  
**(Please complete Sections A, B, C, D and E for each Generator)**

<p>A. Name and Location of Generator</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p> <p>B. County code _____</p>	<p>C. Type of Generator _____</p> <p>If Other, Specify _____</p> <p>D. Quantity of Regulated Medical Waste Accepted from Generator</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p> <p>E. Generator Identification Number</p> <p>_____</p>
<p>A. Name and Location of Generator</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p> <p>B. County code _____</p>	<p>C. Type of Generator _____</p> <p>If Other, Specify _____</p> <p>D. Quantity of Regulated Medical Waste Accepted from Generator</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p> <p>E. Generator Identification Number</p> <p>_____</p>
<p>A. Name and Location of Generator</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p> <p>B. County code _____</p>	<p>C. Type of Generator _____</p> <p>If Other, Specify _____</p> <p>D. Quantity of Regulated Medical Waste Accepted from Generator</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p> <p>E. Generator Identification Number</p> <p>_____</p>
<p>A. Name and Location of Generator</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p> <p>B. County code _____</p>	<p>C. Type of Generator _____</p> <p>If Other, Specify _____</p> <p>D. Quantity of Regulated Medical Waste Accepted from Generator</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p> <p>E. Generator Identification Number</p> <p>_____</p>

**IV. TRANSPORTER IDENTIFICATION (RMW received)**

<p><b>9. Total Number of Transporters From which Regulated Medical Waste was Received _____ . (If your answer is "0", Skip this Section)</b></p>	
<p><b>10. Identity of Transporters - If you transported waste to your facility yourself please include your own totals in this section. (Please complete Sections A and B for each Transporter)</b></p>	
<p>A. Name and Location of Transporter</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Received from Transporter</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>
<p>A. Name and Location of Transporter</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Received from transporter</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>
<p>A. Name and Location of Transporter</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Received from transporter</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>
<p>A. Name and Location of Transporter</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Received From Transporter</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>

**V. TRANSPORTER IDENTIFICATION (RMW offered)**

<p><b>11. Total Number of Transporters to which Regulated Medical Waste was Offered for Transport Off-Site _____ . (If your answer is "0", Skip this Section)</b></p>	
<p><b>12. Identity of Transporters - If you transported the waste off-site yourself please list your own transport totals in this section. (Please complete Sections A and B for each Transporter)</b></p>	
<p>A. Name and Location of Transporter</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Offered to Transporter</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>
<p>A. Name and Location of Transporter</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Offered to Transporter</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>
<p>A. Name and Location of Transporter</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Offered to Transporter</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>
<p>A. Name and Location of Transporter</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Offered to Transporter</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>

**VI. TRANSFER STATION/TRANSFER FACILITY IDENTIFICATION**

**13. Total Number of Transfer Stations or Transfer Facilities to which Regulated Medical Waste was Delivered \_\_\_\_\_.** (If your answer is "0", Skip this Section)

**14. Identity of Transfer Stations or Transfer Facilities**  
**(Please complete Sections A and B for each Facility)**

<p>A. Name and Location of <input type="checkbox"/> Transfer Facility  <input type="checkbox"/> Transfer Station</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Delivered to Transfer Facility/Transfer Station</p> <p>Untreated_____pounds</p> <p>Treated_____pounds</p>
<p>A. Name and Location of <input type="checkbox"/> Transfer Facility  <input type="checkbox"/> Transfer Station</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Delivered to Transfer Facility/Transfer Station</p> <p>Untreated_____pounds</p> <p>Treated_____pounds</p>
<p>A. Name and Location of <input type="checkbox"/> Transfer Facility  <input type="checkbox"/> Transfer Station</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Delivered to Transfer Facility/Transfer Station</p> <p>Untreated_____pounds</p> <p>Treated_____pounds</p>
<p>A. Name and Location of <input type="checkbox"/> Transfer Facility  <input type="checkbox"/> Transfer Station</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Delivered to Transfer Facility/Transfer Station</p> <p>Untreated_____pounds</p> <p>Treated_____pounds</p>

**VII. INTERMEDIATE HANDLER AND DESTINATION FACILITY IDENTIFICATION**

**15. Total Number of Intermediate Handlers and Destination Facilities which Accepted Regulated Medical Waste for Disposal \_\_\_\_\_.**  
**(If your answer is "0", skip this Section)**

**16. Identity of Intermediate Handlers and Destination Facilities**  
**(Please complete Sections A, B and C for each Facility)**

A. Name and Location of  
 Intermediate Handler  
 Destination Facility (Check one)  
 \_\_\_\_\_  
 Name  
 \_\_\_\_\_  
 Address  
 \_\_\_\_\_  
 City, State and Zip Code

B. Facility Type \_\_\_\_\_  
 C. Quantity of Regulated Medical Waste  
 Delivered to Intermediate Handler/Destination  
 Facility  
 Untreated \_\_\_\_\_ pounds  
 Treated \_\_\_\_\_ pounds

A. Name and Location of  
 Intermediate Handler  
 Destination Facility (Check one)  
 \_\_\_\_\_  
 Name  
 \_\_\_\_\_  
 Address  
 \_\_\_\_\_  
 City, State and Zip Code

B. Facility Type \_\_\_\_\_  
 C. Quantity of Regulated Medical Waste  
 Delivered to Intermediate Handler/Destination  
 Facility  
 Untreated \_\_\_\_\_ pounds  
 Treated \_\_\_\_\_ pounds

A. Name and Location of  
 Intermediate Handler  
 Destination Facility (Check one)  
 \_\_\_\_\_  
 Name  
 \_\_\_\_\_  
 Address  
 \_\_\_\_\_  
 City, State and Zip Code

B. Facility Type \_\_\_\_\_  
 C. Quantity of Regulated Medical Waste  
 Delivered to Intermediate Handler/Destination  
 Facility  
 Untreated \_\_\_\_\_ pounds  
 Treated \_\_\_\_\_ pounds

A. Name and Location of  
 Intermediate Handler  
 Destination Facility (Check one)  
 \_\_\_\_\_  
 Name  
 \_\_\_\_\_  
 Address  
 \_\_\_\_\_  
 City, State and Zip Code

B. Facility Type \_\_\_\_\_  
 C. Quantity of Regulated Medical Waste  
 Delivered to Intermediate Handler/Destination  
 Facility  
 Untreated \_\_\_\_\_ pounds  
 Treated \_\_\_\_\_ pounds

**VIII. FINAL DISPOSAL FACILITY IDENTIFICATION**

**17. Total Number of Final Disposal Facilities which accepted Regulated Medical for Disposal \_\_\_\_\_.**  
**(Complete this section if you delivered any waste to a transporter or transfer facility and not directly to an intermediate handler or destination facility)**

**18. Identity of Final Disposal Facilities**  
**(Please complete Sections A, B and C for each Facility)**

<p>A. Name and Location</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Facility Type _____</p> <p>C. Quantity of Regulated Medical Waste Accepted by the Final Disposal Facility</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>
<p>A. Name and Location</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Facility Type _____</p> <p>C. Quantity of Regulated Medical Waste Accepted by the Final Disposal Facility</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>
<p>A. Name and Location</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Facility Type _____</p> <p>C. Quantity of Regulated Medical Waste Accepted by the Final Disposal Facility</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>
<p>A. Name and Location</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State and Zip Code</p>	<p>B. Facility Type _____</p> <p>C. Quantity of Regulated Medical Waste Accepted by the Final Disposal Facility</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>

**IX. FACILITY STATUS**

**19. Has your Collection Facility ceased operation?**

Date of shutdown: \_\_\_\_\_ Temporary \_\_\_\_\_ Permanent \_\_\_\_\_

If Temporary, Explain \_\_\_\_\_

**20. Will your Facility seek to renew permits or continue to operate this unit in the future?**

Yes \_\_\_\_\_ No \_\_\_\_\_

This report must be submitted by July 30, 2009 to the following address:

New Jersey Department of Environmental Protection  
Solid & Hazardous Waste Management Program  
Bureau of Landfill and Hazardous Waste Permitting  
P.O. Box 414  
401 East State Street  
Trenton, NJ 08625-0414