NEW JERSEY REGULATED MEDICAL WASTE
COMMERCIAL COLLECTION FACILITY ANNUAL REPORT

(revised March 2021)

NEW JERSEY DEPARTMENT OF ENVIRONMENTAL PROTECTION
Division of Solid & Hazardous Waste
Bureau of Recycling & Hazardous Waste Management
(609) 984-3438

I. COMMERCIAL COLLECTION FACILITY IDENTIFICATION INFORMATION

1. Reporting period 7/01/ ___ (previous year) through 6/30/ ___ (current year) Due 7/30/ __ (current year)

2. Facility Name and Mailing Address

_____
Name

_____
Address

_____
City, State & Zip Co

3. NJDEP Facility Identification Number

_____

4. Contact Person

Name (Please Print) Title Telephone Number ( )

5. Certification

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

6. Total Quantity of Regulated Medical Waste by Category and Destination

	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)

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

IV. TRANSPORTER IDENTIFICATION (RMW received)

9. Total Number of Transporters From which Regulated Medical Waste was Received _____.
(If your answer is "0", Skip this Section)

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)

A. Name and Location of Transporter	B. Quantity of Regulated Medical Waste Received from Transporter
_____ Name _____ Address _____ City, State, and Zip Code	Untreated_____pounds Treated_____pounds
A. Name and Location of Transporter _____ Name _____ Address _____ City, State, and Zip Code	B. Quantity of Regulated Medical Waste Received from transporter Untreated_____pounds Treated_____pounds
A. Name and Location of Transporter _____ Name _____ Address _____ City, State, and Zip Code	B. Quantity of Regulated Medical Waste Received from transporter Untreated_____pounds Treated_____pounds
A. Name and Location of Transporter _____ Name _____ Address _____ City, State, and Zip Code	B. Quantity of Regulated Medical Waste Received From Transporter Untreated_____pounds Treated_____pounds

V. TRANSPORTER IDENTIFICATION (RMW offered)

11. Total Number of Transporters to which Regulated Medical Waste was Offered for Transport Off-Site __________. (If your answer is "0", Skip this Section)

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)

A. Name and Location of Transporter	B. Quantity of Regulated Medical Waste Offered to Transporter
______________________ Name ______________________ Address ______________________ City, State, and Zip Code	Untreated______________pounds Treated______________pounds
A. Name and Location of Transporter ______________________ Name ______________________ Address ______________________ City, State, and Zip Code	B. Quantity of Regulated Medical Waste Offered to Transporter Untreated______________pounds Treated______________pounds
A. Name and Location of Transporter ______________________ Name ______________________ Address ______________________ City, State, and Zip Code	B. Quantity of Regulated Medical Waste Offered to Transporter Untreated______________pounds Treated______________pounds
A. Name and Location of Transporter ______________________ Name ______________________ Address ______________________ City, State, and Zip Code	B. Quantity of Regulated Medical Waste Offered to Transporter Untreated______________pounds Treated______________pounds

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)

A. Name and Location of ☐ Transfer Facility ☐ Transfer Station _______________________________ Name _______________________________ Address _______________________________ City, State, and Zip Code	B. Quantity of Regulated Medical Waste Delivered to Transfer Facility/Transfer Station Untreated______________pounds Treated______________pounds
A. Name and Location of ☐ Transfer Facility ☐ Transfer Station _______________________________ Name _______________________________ Address _______________________________ City, State, and Zip Code	B. Quantity of Regulated Medical Waste Delivered to Transfer Facility/Transfer Station Untreated______________pounds Treated______________pounds
A. Name and Location of ☐ Transfer Facility ☐ Transfer Station _______________________________ Name _______________________________ Address _______________________________ City, State, and Zip Code	B. Quantity of Regulated Medical Waste Delivered to Transfer Facility/Transfer Station Untreated______________pounds Treated______________pounds
A. Name and Location of ☐ Transfer Facility ☐ Transfer Station _______________________________ Name _______________________________ Address _______________________________ City, State, and Zip Code	B. Quantity of Regulated Medical Waste Delivered to Transfer Facility/Transfer Station Untreated______________pounds Treated______________pounds

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)

A. Name and Location ___________________________________ Name ___________________________________ Address ___________________________________ City, State, and Zip Code	B. Facility Type ___________________ C. Quantity of Regulated Medical Waste Accepted by the Final Disposal Facility Untreated______________pounds Treated______________pounds
A. Name and Location ___________________________________ Name ___________________________________ Address ___________________________________ City, State, and Zip Code	B. Facility Type ___________________ C. Quantity of Regulated Medical Waste Accepted by the Final Disposal Facility Untreated______________pounds Treated______________pounds
A. Name and Location ___________________________________ Name ___________________________________ Address ___________________________________ City, State, and Zip Code	B. Facility Type ___________________ C. Quantity of Regulated Medical Waste Accepted by the Final Disposal Facility Untreated______________pounds Treated______________pounds
A. Name and Location ___________________________________ Name ___________________________________ Address ___________________________________ City, State, and Zip Code	B. Facility Type ___________________ C. Quantity of Regulated Medical Waste Accepted by the Final Disposal Facility Untreated______________pounds Treated______________pounds

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 7/30/___ (current year) to the following address:

Mail Code: 401-02C
New Jersey Department of Environmental Protection
Division of Solid & Hazardous Waste
Bureau of Recycling & Hazardous Waste Management
P.O. Box 420
401 East State Street
Trenton, NJ 08625-0420