

NEW JERSEY REGULATED MEDICAL WASTE
COMMERCIAL COLLECTION FACILITY ANNUAL REPORT
(revised November 2010)

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

1. Reporting period 7/01/ ____ (previous year) through 6/30/ ____ (current year) Due 7/30/ __ (current year)		
2. Facility Name and Mailing Address		3. NJDEP Facility Identification Number
_____ Name		_____
_____ Address		
_____ City, State & Zip Co		
4. Contact Person		
_____		(____) _____
Name (Please Print)	Title	Telephone Number
5. Certification		
<p>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.</p>		
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)

<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)

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)

<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)**

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)

<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

<p>19. Has your Collection Facility ceased operation? Date of shutdown: _____ Temporary _____ Permanent _____ If Temporary, Explain _____</p>
<p>20. Will your Facility seek to renew permits or continue to operate this unit in the future? Yes _____ No _____</p>

This report must be submitted by 7/30/____ (current year) to the following address:

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