

**APPLICATION PACKET FOR LARGE QUANTITY MEDICAL
WASTE GENERATORS WITH ON/OFF-SITE TREATMENT,
COMMON STORAGE,
AND
SMALL QUANTITY MEDICAL WASTE GENERATORS WITH
ON-SITE TREATMENT**

This packet contains the information and forms you will need to comply with Riverside County Ordinance 718.1 and the Californian State Health and Safety Code Sections 117600-118360, Medical Waste Management Act.

Instructions

1. Please complete the following:
 - a. Permit application
 - b. Medical Waste Management Plan (**If your medical waste management plan has not changed from the previous year please check the appropriate box on page 3 and sign page 3 of this application**).
2. Please attach the following
 - a. Employee Training Plan (**If not different from the previous year, see page 3**).
3. Please submit the completed application, attachments and appropriate fees within 30 days to:

**County of Riverside County
Community Health Agency
Department of Environmental Health
4080 Lemon Street
P.O. Box 1280
Riverside, CA 92502-1280**

If you have any questions regarding the information required, please feel free to contact the Local Enforcement Agency at (951) 955-8982.

Note: All new facilities that treat medical waste on-site are required to submit environmental clearances from the local planning department.

**PERMIT APPLICATION FOR LARGE QUANTITY MEDICAL
WASTE GENERATORS WITH ON/OFF-SITE TREATMENT,
COMMON STORAGE,
AND
SMALL QUANTITY MEDICAL WASTE GENERATORS WITH
ON-SITE TREATMENT**

Note: This application will not be processed until all required information has been received.

Generator's Name _____

Site Address _____

City _____ State _____ Zip _____

Mailing Address _____

City _____ State _____ Zip _____

Phone (_____) _____ - _____

Name of legal owner of facility _____

Ownership Status _____
(Federal, state, local government, or other public or private entity)

Mailing Address _____

City _____ State _____ Zip _____

Phone (_____) _____ - _____

Authorized Representative _____

Title _____

Emergency Phone Number (_____) _____ - _____

This facility is currently a:

- Large quantity generator (generating more than 200 lbs/mo.)
- Large quantity generator with on-site treatment
- Small quantity generator (generating less than 200 lbs/mo.) with on-site treatment
- Limited Quantity Hauling Exemption for facilities that provide home health care/visiting nurses.

**All home visits to outpatients by visiting nurses requires a Limited Quantity Hauling Exemption pursuant to Riverside County Ordinance 718.1 and Medical Waste Management Act, Section 118030.*

TYPE OF FACILITY:

- Common Storage:** 10 or fewer generators 11 to 50 generators
- 50 or more generators
- Acute Care Hospital
- Laboratory Blood Bank Psychiatric Hospital Clinic-Specify _____
- Intermediate Care Facility Health Care Service Plan Facility
- Veterinary Clinic or Hospital Medical Office

Type of Facility (small quantity generator with on-site treatment)

- Clinic-Specify _____
- Medical Office
- Dental Office
- Veterinary Office
- Other _____

PLEASE INCLUDE THE APPROPRIATE FEES AND ATTACH THE COMPLETED FORMS.

- Medical Waste Management Plan has **not** changed from the previous year and is on file for review by the Department of Environmental Health.
- Employee Training Plan has **not** changed from the previous year and is on file for review by the Department of Environmental Health.

I certify under penalty of perjury that this document and all attachments have been prepared under my direction and supervision in accordance with a system to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons, who manage the system or those, directly responsible for gathering the data, 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 possibility of a fine and imprisonment. I hereby consent to all necessary inspections made pursuant to the California Medical Waste Management Act and incidental to the issuance of this permit and the operation of this business.

Name: _____

Title: _____

Signature: _____

Date: _____

MEDICAL WASTE MANAGEMENT PLAN

Name of Facility _____

Site Address _____

City _____ State _____ Zip _____

Mailing Address _____

City _____ State _____ Zip _____

Phone (_____) _____ - _____

Person responsible for implementation of management plan:

Name _____

Title _____

Phone (_____) _____ - _____

Types of waste generated:

- Laboratory wastes – specimen or microbiological cultures, stocks of infectious agents, live and attenuated vaccines, and culture mediums.
- Blood or body fluids waste – liquid blood elements or other regulated body fluids, or articles contaminated with blood or body fluids.
- Sharps waste – syringes, needles, blades, broken glass.
- Contaminated animal's waste – animal carcasses, body parts, bedding materials.
- Isolation waste – waste contaminated with excretion, exudates, or secretions from humans or animals that are isolated due to highly communicable diseases (Center for Disease Control, Biosafety Level 4)*
- Pharmaceutical wastes – California only hazardous pharmaceutical waste.
- Surgical/Autopsy specimen waste
- Pathology waste
- Trace chemotherapy waste
- Other – Specify _____

Estimate of monthly quantity generated _____ pounds.

**Biosafety Level 4 viruses and diseases are: Congo-Crimean hemorrhagic fever, Tick-borne encephalitis virus complex (Absettarov, Hanzalova, Hypr, Kumlinge, Kyasanur Forest disease, Omsk hemorrhagic fever, and Russian Spring-Summer encephalitis), Marburg disease, Ebola, Junin virus, Lassa fever virus, Machupo virus.*

Method of treatment if performed on-site:

Incineration Autoclave Microwave

Other _____

Describe the following methods used in handling of medical waste:

Segregation from other wastes:

Containment or packaging procedures:

Labeling and collection procedures:

MEDICAL WASTE ACCEPTED FROM OTHER FACILITIES

Medical waste accepted for: Consolidation Treatment

Facility Name _____

Address _____

City _____ State _____ Zip _____

Contact Person _____

Phone (_____) _____ - _____

Medical waste accepted for: Consolidation Treatment

Facility Name _____

Address _____

City _____ State _____ Zip _____

Contact Person _____

Phone (_____) _____ - _____

Medical waste accepted for: Consolidation Treatment

Facility Name _____

Address _____

City _____ State _____ Zip _____

Contact Person _____

Phone (_____) _____ - _____

HAZARDOUS WASTE HAULER

Facility Name _____

Address _____

City _____ State _____ Zip _____

Contact Person _____

Phone (_____) _____ - _____

TREATMENT/DISPOSAL FACILITY

Facility Name _____

Address _____

City _____ State _____ Zip _____

Contact Person _____

Phone (_____) _____ - _____

I hereby certify that to the best of my knowledge and belief the statements made herein are correct and true.

Name _____

Title _____

Signature _____

Date _____

Note: All medical waste generators are required to keep accurate tracking records relative to containment, storage, hauling, treatment and disposal for a period of 3 years. (MWMA Section 117975)