sanitation

ENVIRONMENTAL POLICE UNIT
465 Hamilton Avenue
Brooklyn, New York 11232
Telephone (212) 437-4452
Fax (212) 437-4599

Annual 2015

SOLID WASTE REMOVAL PLAN

Annual Filing Date _____

GENERATOR INFORMATION

PLEASE PRINT

Generator Name (no abbrev.) _____

Street _____

City _____ State _____ Zip Code _____

County _____

Email Address _____

INSTITUTION

Please circle all pertaining information

| CITY | STATE | FEDERAL | PRIVATE-PROFIT | PRIVATE-NONPROFIT

Contact Person

Name _____

Title _____ Tel # ( ) _____

Type of Generator

| Hospital | Laboratory
| Veterinary Clinic | Private Clinic
| Nursing Home | Dentist
| Medical Doctor | Podiatry
| Acupuncture | Other

(describe other) _____

KEEP NYC CLEAN * REDUCE, REUSE, RECYCLE * DON'T LITTER

printed on recycled paper

PLEASE ATTACH A LIST OFF ALL SATELLITE FACILITIES AND COMPLETE SEPARATE SOLID WASTE REMOVAL PLAN FOR EACH

Type of Regulated Medical Waste Generated (check all that apply)

- | Isolation Waste
- | Sharps
- | Human Blood/Blood Products
- | Contaminated Animal Carcasses
- | Dialysis Waste
- | Laboratory Waste
- | Human Pathological Waste
- | Cultures and Stocks of Infectious Agents
- | Waste from surgery or autopsy

- | Other (describe)_____

Generator Waste Information

A. Approximate quantity of regulated medical waste generated at this address.
lbs/month _____

1. How many pickups per week/month_____

B. Approximate quantity of solid waste (Reg. Garbage) generated at this address.
cubic yds/month _____

C. Amount of regulated medical waste received from outside sources (ex.doctor offices,annex)

_____

_____

_____

_____

_____

REGULATED MEDICAL WASTE TRANSPORTER - Contact Information

Transporter Name (no abbrev.) _____

Street _____

City _____ State _____ Zip Code _____

Contact Person _____ Tel # _____

DEC Permit Number _____

Disposal Site

Name (no abbrev.) _____

Street _____

City _____ State _____ Zip Code _____

Tel # _____

IMPORTANT NOTICE

PLEASE ENCLOSE A COPY OF YOUR MOST RECENT MEDICAL WASTE TRACKING FORM (DISPOSAL FACILITY SIGNATURE COPY)

DISPOSAL OF SOLID WASTE (Regular Trash) - Contact Information

Carter's Name(no abbrev.) _____

Street _____

City _____ State _____ Zip Code _____

Contact Person _____ Tel # _____

Business Integrity Commission Number (BIC) _____

Disposal Site

Name (no abbrev.) _____

Street _____

City _____ State _____ Zip Code _____

Tel # _____

CERTIFICATION

I certify that I have personal knowledge of the information submitted in this document. And this information is true, accurate, and complete.

Please Print Name and official title of owner, owner's authorized representative, or person in charge.

Name _____

Title _____

Date _____

Signature _____

REMINDER

PLEASE ENCLOSE A COPY OF YOUR MOST RECENT MEDICAL WASTE TRACKING FORM (MANIFEST)

(DISPOSAL FACILITY SIGNATURE COPY)

NOTE: Not submitting a tracking form (manifest) or not completing all requested information will be considered as a (non) filed solid waste removal plan.

SEND COMPLETED FORM TO:

Certified mail recommended

New York City Department of Sanitation
Environmental Police Unit
465 Hamilton Avenue
Brooklyn, New York, 11232