



ANDREW M. CUOMO Governor

HOWARD A. ZUCKER, M.D., J.D. Commissioner

SALLY DRESLIN, M.S., R.N. Executive Deputy Commissioner

Regulated Medical Waste Treatment Certification

ITEMS 1-9 TO BE COMPLETED BY TREATMENT FACILITY SEE REVERSE SIDE FOR INSTRUCTIONS

1. Facility Name: Address: 2. DOH Laboratory PFI No.: DOH Health Care Facility PFI No.: 3. County: DEC State Permit No.: 4. Phone #: Fax#: 5. Contact Person

REGULATED MEDICAL WASTE INFORMATION

6. Weight (in pounds) and date treated 7. Description of Contents of Regulate Medical Waste Shipment Check applicable category(ies): 8. Method of Treatment: 9. Under Penalty of criminal and civil prosecution for making or submitting false statements or representation, I swear or affirm that the statements herein accurately describe the regulated medical waste to which this certificate relates, and that the treatment is in accordance with the requirements as set forth in Part 70 of 10 NYCRR. Name of authorized individual of facility Signature of authorized individual of facility Date

ITEMS 1-12 TO BE COMPLETED BY TRANSPORTER

10. Name, Address and Telephone Number of Transporter: 11. Name, Address and Telephone Number of Transporter:

12. Name, Title and Telephone Number of Disposal Facility Contact Person: THIS FORM SHOULD ACCOMPANY ALL TREATED REGULATED MEDICAL WASTE TO THE FINAL DISPOSAL SITE. It is recommended that generators maintain copies of this form for two years.

## INSTRUCTIONS FOR FILLING OUT THE CERTIFICATION FORM BY ITEM NUMBER

1. Facility's complete legal name and address.
2. New York State Department of Environmental Conservation (DEC) Permit to Operate number or New York State Department of Health (DOH) laboratory or health care facility Permanent Facility Identification (PFI) number.
3. County in which the treatment took place.
4. Telephone number and facsimile (fax) transmission number of the contact person listed in Item Number 5.
5. Contact person's full name and title. This person is responsible for all activities related to the management of regulated medical waste at the facility governed by the regulations.
6. Total weight in pounds of treated regulated medical waste which is being accompanied by this form to an authorized disposal facility. Also, for waste contained in the shipment list the date or range of dates on which waste was treated and/or rendered unrecognizable.
7. Describe contents of waste shipment by checking appropriate category(ies).
8. Describe the method of treatment of regulated medical waste by checking the appropriate boxes. If treatment is by an alternative technology, list the name, model number and manufacturer of the system.
9. An authorized individual of the treatment facility must sign and date the form.
10. Complete name, address and telephone number of the transporter of regulated medical waste from the treatment facility.
11. Complete legal name and address of disposal facility receiving the waste.
12. Complete legal name, title and telephone number of the authorized disposal facility contact person.