1270 Natividad Road
Salinas, CA 93906

**MONTEREY COUNTY HEALTH DEPARTMENT**
**ENVIRONMENTAL HEALTH BUREAU**

Tel: (831) 755-4505
Fax: (831) 796-8693

# MEDICAL WASTE MANAGEMENT PLAN

**(California Health and Safety Code, Sections 117935 & 117960)**

## I. FACILITY INFORMATION:

**BUSINESS NAME:**

Location Address: City: Zip:

Phone: Fax: Email:

Name of Contact: Title: Phone:

## II. REGULATED MEDICAL WASTE: Check all that apply (see back for definitions)

☐ Sharps ☐ Biohazardous ☐ Pathology ☐ Chemotherapy ☐ Pharmaceutical

1. Estimated avg. monthly quantity of medical waste generated is _____ pounds.

☐ < 200 lbs. - Small Quantity Generator (SQG) ☐ Home Generation Consolidation Point (HGCP)
☐ > 200 lbs. - Large Quantity Generator (LQG) Circle if applicable: Sharps / Pharmaceuticals

2. Do you treat medical waste onsite (that is, in your office or facility)

☐ Yes ☐ No

A. If so, what treatment method do you use? _____

B. What is your treatment capacity? (Only large generators need to declare capacity)

_____

3. Does your facility accept medical waste generated offsite (i.e. offsite clinic, lab, community event)?

☐ Yes ☐ No

4. Does your facility self-transport medical waste?

☐ Yes ☐ No

A. If so, where is it transported? _____

5. Does your facility use a certified medical waste hauler? ☐ Yes ☐ No

A. If so, please provide the following information:

Name of Certified Medical Waste Hauler:

Address:

Collection frequency:

Account number:

6. Does your facility generate hazardous or radioactive waste?

☐ Yes ☐ No

A. If so, please supply the following information regarding the registered hazardous waste hauler:

Name:

Address:

Collection frequency: Account number:

Disposal Facility Used

Name:

Address

7. Does your facility operate a common storage facility?

☐ Yes ☐ No

A. If so, please list the business name/address of each small quantity generator using this common storage facility.

_____

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8. Will your facility apply or have you applied for a Materials of Trade Exemption (MTE)?

☐ Yes ☐ No

A. If so, please list the names and job titles of staff authorized to be MTE haulers:

Title: _____

Title: _____

Title: _____

B. Facility name and address where medical waste is hauled:

Name: _____

Address: _____

Phone No. _____

9. Will medical waste be hauled to a treatment facility other than that used by your certified medical waste hauler?

☐ Yes ☐ No

A. If so, please give name/address:

Name: _____

Address: _____

Phone No. _____

10. In the event of failure of the plan describe above, (e.g., equipment failure, natural disaster) what will be the alternative method of treatment and/or disposal of medical waste?

_____

_____

_____

11. How will your facility manage a **medical waste spill?**

_____

_____

_____

12. How is liquid/semi-liquid laboratory waste treated?

_____

_____

**Note: Medical waste generators must keep accurate records relative to storage, hauling, treatment and disposal of medical waste for a minimum of three (3) years.**

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

Signature: _____ Date: _____

Title: _____

This format for a Medical Waste Management Plan was developed by the County of Monterey Department of Health, Division of Environmental Health, Solid Waste Section. For more information on the Medical Waste Management Plan please refer to the Medical Waste Management Act, which can be found on the web at:
https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/MedicalWaste.aspx