

# ENVIRONMENTAL HEALTH DEPARTMENT

## SAN JOAQUIN COUNTY



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### INFORMATION PACKET FOR MEDICAL WASTE GENERATORS

This packet contains the information and forms you will need to help you comply with the Medical Waste Management Act.

#### Instructions

Please return the completed forms prior to medical waste generation or treatment.

1. Complete the **“Pre-Application Questionnaire”** on Page 2. If your answers indicate you are not required to register as a medical waste generator, then complete the **“Certification Statement”** on Page 3 and return both complete forms to the mailing address below.
2. If you are required to register as a medical waste generator, as indicated by affirmative answers to questions 3 & 4 on the **“Pre-Application Questionnaire”**, then:
  - a. Complete the **“Registration for Medical Waste”** form located on Page 4.
  - b. Complete a **“Medical Waste Management Plan”** following the guidelines provided on Page 5.
  - c. Return the completed forms and management plan to the mailing address below.

Your cooperation in promptly registering and following the specified handling requirements is greatly appreciated.

If you have any questions regarding registration or handling requirements, please contact (209) 468-3420 and ask for the Medical Waste Program.

#### **RETURN ALL COMPLETED FORMS TO:**

Attn: Medical Waste Program  
San Joaquin County Environmental Health Department  
600 East Main Street  
Stockton, CA 95202

# PRE-APPLICATION QUESTIONNAIRE

## Regulated Medical Wastes

Please check the appropriate box for the questions listed below:

- Pharmaceuticals:** prescription or over-the-counter human or veterinary drug, including, but not limited to, a drug as defined in Section 109925 or the Federal Food, Drug, and Cosmetic Act, as amended, [21 U.S.C.A. Sec. 321(g)(1)]. This definition does not include RCRA waste.
- Laboratory Wastes:** specimen or microbiologic cultures, stocks of infectious agents, live and attenuated vaccines and culture mediums.
- Blood or Body Fluids:** liquid blood elements, other regulated body fluids, articles contaminated with blood or body fluids.
- Sharps:** syringes, needles, blades and contaminated broken glass.
- Contaminated Animals:** animal carcasses, body parts and bedding materials.
- Surgical Specimens:** human or animal parts or tissues removed surgically or by autopsy.
- Isolation Wastes:** waste contaminated with excretion, exudates, or secretions from humans or animals who are isolated due only to the highly communicable diseases listed by the Centers for Disease Control as requiring Biosafety Level IV precautions.

1. Does your business or service generate any of the medical waste listed above?  Yes  No  
If your answer is “No”, please complete the “**Certification Statement**” on Page 4 and return it with this questionnaire to the address indicated. You do not need to complete the remainder of this questionnaire and you do not need to pay a fee.
2. Do you generate less than 200 pounds of medical waste per month?  Yes  No  
If you answered “Yes”, you are a small generator.
3. Small generators may store their medical waste in a permitted Common Storage Facility with other small generators. Do you plan to do this at your facility?  Yes  No  
If your answer is “Yes”, you must obtain a “**Common Storage Facility Permit**” from this office.
4. Do you plan to treat your medical waste onsite (at your facility), by autoclaving, incinerating or using microwave technology?  Yes  No  
If you are a small generator and your answers to question 3 & 4 are “No”, then complete the “**Certification Statement**” on Page 3 and return it with this questionnaire to the letterhead address. You do not need to complete the rest of this package.  
If your answer to this question is “Yes”, you must complete Pages 4 & 5 and return them with this questionnaire and the appropriate fee to the address indicated on Page 1.
5. If you generate less than 20 pounds of medical waste per week, transport less than 20 pounds at one time, and have a hauling information document on file in your office, you may apply for a Limited Quantity Hauling Exemption from this office. This exemption allows you or your staff to transport medical waste to a medical waste treatment facility. Do you want to apply for a Limited Quantity Hauling Exemption?  Yes  No

# Certification Statement

FOR NON-MEDICAL WASTE GENERATORS AND MEDICAL WASTE GENERATORS NOT REQUIRED TO REGISTER

Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

City

State

Zip Code

Phone Number: (\_\_\_\_) \_\_\_\_\_

Contact Person: \_\_\_\_\_

I am not required to register as a Medical Waste Generator because:

*Please check the appropriate statement(s)*

- I do not generate any medical waste.
- I generate less than 200 pounds of medical waste per month.
- I do not treat any medical waste at my facility by means of autoclaving, incinerating or microwaving.
- Other: \_\_\_\_\_  
\_\_\_\_\_

**Please indicate the appropriate statement(s):**

- I declare under penalty of law that to the best of my knowledge and belief, I do not generate or store any of the wastes specified on the **“Pre-Application Questionnaire”** as regulated medical wastes in an amount that equals or exceeds 200 pounds per month.
- I declare under penalty of law that I will not be treating any amount of regulated medical wastes at my facility by way of autoclaving, incinerating or microwaving.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

# Registration for Medical Waste For Generators of Medical Waste

**GENERATOR NAME:** \_\_\_\_\_

Generator **Facility** Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_  
City State Zip Code  
( )

Generator **Mailing** Address: \_\_\_\_\_

City State Zip Code

Type of Business: \_\_\_\_\_

Authorized Representative: \_\_\_\_\_

Title: \_\_\_\_\_

Emergency Phone Number: ( ) \_\_\_\_\_

**REGISTRATION FOR:**

- Small Quantity Generator with Onsite Treatment (Generates less than 200 lbs/month).
- Large Quantity Generator Only (Generates 200 lbs or more/month).
- Large Quantity Generator with Onsite Treatment (Generates 200 lbs or more/month).

**I declare under penalty of law that to the best of my knowledge and belief the statements made herein are correct and true. I hereby consent to all necessary inspections made pursuant to the California Medical Waste Management Act and incidental to the issuance of this registration and the operation of this business.**

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

# GUIDELINES FOR THE MEDICAL WASTE MANAGEMENT PLAN

Small quantity generators that provide Onsite Treatment and all large quantity generators shall have a Medical Waste Management plan on file with the San Joaquin County Environmental Health Department. The Medical Waste Management Plan shall contain the following information as appropriate for your facility:

Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip Code

Phone Number: ( ) \_\_\_\_\_

Type of Facility or Business: \_\_\_\_\_

## REGISTRATION FOR:

- Small Quantity Generator with Onsite Treatment (Generates less than 200lbs/month).
- Large Quantity Generator Only (Generates 200 lbs or more/month).
- Large Quantity Generator with Onsite Treatment (Generates 200 lbs or more/month).

Person responsible for implementation of the Medical Waste Management Plan:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

1. List the types of medical waste generated at your facility, i.e., laboratory wastes, blood or body fluids, sharps, contaminated animals, surgical specimens, trace chemo or isolation wastes”:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- a) Do you generate **any pharmaceutical waste** (expired/outdated, spent, partials,)?
- b)  Yes  No

If yes, describe the type of **pharmaceutical waste** (expired, spent, partials, outdated, patient returns, etc):

\_\_\_\_\_

And estimate the monthly amount of **pharmaceutical waste** generated at your facility: \_\_\_\_\_

2. Estimate the monthly amount of medical waste (excluding waste pharmaceuticals) generated at your facility: \_\_\_\_\_  
\_\_\_\_\_

3. Describe the medical waste handling procedures utilized by and applicable to your facility, including, but not limited to the following:

a. Onsite location and method for segregation, containment, packaging, labeling and collection, **including pharmaceutical waste**: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. Storage area description with storage methods utilized for each waste stream **including any pharmaceutical waste**: \_\_\_\_\_  
\_\_\_\_\_

c. If medical waste is treated onsite, describe the treatment facility including type of treatment utilized, maximum capacity, time and temperature necessary, alternate contingency plan in case of equipment failure, etc:  
\_\_\_\_\_  
\_\_\_\_\_

d. Name, address, registration number and phone number of the registered **hazardous waste hauler** employed by your facility for **biohazardous** (excluding pharmaceutical waste) and **sharps waste**:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City State Zip Code  
Phone: ( ) \_\_\_\_\_  
Registration #: \_\_\_\_\_

e. Name, address, registration number and phone number of the registered **hazardous waste hauler** employed by your facility for **pharmaceutical waste**:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City State Zip Code  
Phone: ( ) \_\_\_\_\_  
Registration #: \_\_\_\_\_

f. Name, address and phone number of **Offsite Treatment Facility** where **biohazardous** (excluding pharmaceutical waste) and **sharps waste** is transported for treatment, if different than hauler:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City State Zip Code

Phone: ( ) \_\_\_\_\_

- g. Name, address and phone number of **Offsite Treatment Facility** where **pharmaceutical waste** is transported for treatment, if different than pharmaceutical waste hauler:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip Code

Phone: ( ) \_\_\_\_\_

- h. All medical waste generators are required to keep accurate records regarding containment, storage, hauling, treatment and disposal. All medical waste records area to be maintained and available for review during inspection for three (3) years. Do you have tracking documents for all medical wastes handled at your facility:  Yes  No

- i. Describe training provided to staff regarding handling, storage, disposal, and record keeping of **all medical waste, including pharmaceutical waste**, at your facility: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- j. Describe your medical waste emergency action plan, including procedures for handling spills, exposures, equipment failures, etc: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

San Joaquin County  
Environmental Health Department

Medical Waste Program Fees

Primary Care.....	\$303.00
Acute Care.....	\$564.00
Skilled Nursing Facility.....	\$403.00
Large Generator.....	\$182.00
Small Generator (with treatment).....	\$55.00
Common Storage Facility (2-10).....	\$154.00
Common Storage Facility (11-50).....	\$305.00
Common Storage Facility (>50).....	\$545.00
Transfer Facility.....	\$424.00
Medical Waste Limited Hauler.....	\$77.00
Veterinary Clinic.....	\$272.00