



CONTRA COSTA
ENVIRONMENTAL HEALTH DIVISION
 2120 DIAMOND BOULEVARD, SUITE 200
 CONCORD, CA 94520
 (925) 692-2500 PHONE | (925) 692-2502 FAX
<http://www.cchealth.org/eh>



MEDICAL WASTE PROGRAM APPLICATION

(APPLICATION FEE IS DUE AND NON-REFUNDABLE)

SECTION 1: Type of Application (**Requires a Medical Waste Management Plan)

- New Facility**
 Change of Facility Ownership**
 Change of Facility Name**
 Change of Accounts Receivable Info

SECTION 2: Type of Facility

- | | | |
|--|---|---|
| <input type="checkbox"/> Med/Dent/Vet Clinic (> 200 lbs./month) | <input type="checkbox"/> Acute Care Hospital (1-99 beds) | <input type="checkbox"/> Biomed Producer (> 200 lbs./month) |
| <input type="checkbox"/> Med/Dent/Vet Clinic (< 200 lbs./month) | <input type="checkbox"/> Acute Care Hospital (100-199 beds) | <input type="checkbox"/> Biomed Producer (< 200 lbs./month) |
| <input type="checkbox"/> Med/Dent/Vet Clinic w/ On-site Treatment (>200 lbs./month) | <input type="checkbox"/> Acute Care Hospital (200-250 beds) | <input type="checkbox"/> Common Storage Facility (2-10 generators) |
| <input type="checkbox"/> Med/Dent/Vet Clinic w/ On-site Treatment (< 200 lbs./month) | <input type="checkbox"/> Acute Care Hospital (251+ beds) | <input type="checkbox"/> Common Storage Facility (11-49 generators) |
| <input type="checkbox"/> Skilled Nursing Facility (> 200 lbs./month) | <input type="checkbox"/> Health Care Service Plan | <input type="checkbox"/> Clinical Laboratory (> 200 lbs./month) |
| <input type="checkbox"/> Skilled Nursing Facility (< 200 lbs./month) | <input type="checkbox"/> Specialty Clinics | |

SECTION 3: Contact Information

A. Owner / Permit Holder Information

(If marking an ownership type, please provide proof)

OWNER / PERMIT HOLDER NAME :		<input type="checkbox"/> INC <input type="checkbox"/> LLC <input type="checkbox"/> LP <input type="checkbox"/> CORP	
OWNER MAILING ADDRESS :			
CITY / STATE / ZIP CODE :	PHONE # :	FAX # :	

B. Facility Information

FACILITY NAME / DBA :		
FACILITY ADDRESS :		
CITY / STATE / ZIP CODE :	PHONE # :	FAX # :
FACILITY EMAIL :		

C. Accounts Receivable Information

IN CARE OF (Billing Office or Person in Charge) :		
ACCOUNTS RECEIVABLE ADDRESS :		
CITY / STATE / ZIP CODE :	PHONE # :	FAX # :

SECTION 3: Terms/Signature

Under penalty of law I declare that to the best of my knowledge and belief the information that I have provided is true and accurate. I also agree to conform to all conditions, orders, and directions issued pursuant to the California Health and Safety Code, Section 117600 – 118360 (The Medical Waste Management Act) and all applicable local ordinances.

Signature of Applicant: _____ Date: _____

FOR OFFICE USE ONLY

FA#:	PR#:	AR# :	P/E:	EHS:	RECEIVED BY:	DATE RECEIVED:
AMOUNT DUE: \$	AMOUNT PAID: \$	CHECK #:	METHOD OF PAYMENT: <input type="checkbox"/> CASH/CHK <input type="checkbox"/> MC <input type="checkbox"/> VISA <input type="checkbox"/> D/C			RECEIPT #: XR