

MEDICAL WASTE MANAGEMENT PLAN

Per sections 117945 & 117960 of the California Health & Safety Code, small and large quantity generators of medical waste must maintain an informational document or Medical Waste Management Plan.

BUSINESS NAME:			
BUSINESS ADDRESS:			
BUSINESS PHONE:		FAX:	
BUSINESS E-MAIL:			
NAME OF AUTHORIZED REPRESENTATIVE:			

SECTION I: TYPES OF MEDICAL WASTE GENERATED (Check all that apply)

- Laboratory wastes –specimen or microbiological cultures, stocks of infectious agents, live and attenuated vaccines and culture mediums, vials or vacutainers containing blood or blood products.
- Blood or body fluids – liquid blood elements or other regulated body fluids or articles contaminated with blood or body fluids.
- Sharps – syringes, needles, blades, and broken glass.
- Contaminated animals – animal carcasses, body parts, bedding materials.
- Surgical specimens – human or animal parts or tissues removed surgically or by autopsy. (*Anatomical or Pathology Waste*)
- Chemotherapy waste
- Isolated waste – waste contaminated with excretion, exudate or secretions from humans or animals that are isolated due to highly communicable diseases (***Centers for Disease Control, Biosafety Level 4***).
- Outdated pharmaceuticals (not including chemotherapeutic, antiineoplastic, or cytotoxic drugs)

***Note: Biosafety Level 4 viruses and diseases are Congo-Crimean hemorrhagic fever, Tick-borne encephalitis virus complex (Absettarov, Hanzalova, Hypr, Kumlinge, Kyasanur Forest Disease, Omsk Hemorrhagic Fever, and Russian Spring-Summer Encephalitis), Marburg Disease, Ebola, Junin Virus, Lassa Fever Virus, and Machump Virus.*

SECTION II: FACILITY INFORMATION

1. This facility is classified as a (check one):

- | | | |
|--|---|---|
| <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 | |

2. The estimated quantity of medical waste generated (including sharps waste) by this facility on a monthly basis is _____ lbs.

3. Describe the method of handling, collection, and storage of medical waste within your facility.

4. Describe the use of any disinfection procedures used in your facility for treatment or cleaning of reusable medical waste receptacles and medical waste spills.

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5. Describe the types and frequency of training provided to employees that handle medical waste at your facility.
6. If your facility employs a method of on-site treatment (i.e. autoclave, incineration, steam sterilization) for medical waste generated, enclose the operating procedures for the equipment with this form.
**Note: If ONLY reusable medical instruments or equipment are treated on-site, mark this section as "Not Applicable" or "N/A".

7. Information pertaining to the registered medical waste hauler contracted by your facility:

NAME: _____
ADDRESS: _____
CITY / STATE / ZIP: _____
PHONE: _____

SECTION III: EMERGENCY DISPOSAL

In case of emergency, such as equipment breakdown on the part of the registered hauler or natural disaster, medical waste will be EITHER (check one):

- Stored for up to seven days on the premises. Sufficient storage space is available in _____.

OR

- The following alternate registered biohazardous waste hauler will be utilized:

NAME: _____
ADDRESS: _____
CITY / STATE / ZIP: _____
PHONE: _____

In the event of an emergency or natural disaster, contact Contra Costa Environmental Health (CCEH) at (925) 692-2500 to notify CCEH of any changes or to obtain further instruction(s).

SECTION IV: 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: _____

Print Name: _____