SAN MATEO COUNTY HEALTH
ENVIRONMENTAL HEALTH SERVICES

Environmental Health Services
Medical Waste Program
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MEDICAL WASTE MANAGEMENT PLAN

☐ New Facility ☐ Existing Facility Change Existing FA # _____

FACILITY INFORMATION

Facility Name: _____ Address: _____

Suite or Unit: _____ City: _____ ☐ Unincorporated State: _____ Zip: _____

CONTACT INFORMATION

Primary Contact: _____ Title: _____ Phone: _____ Cell #: _____

Secondary Contact: _____ Title: _____ Phone: _____ Cell #: _____

Who is responsible for and coordinates your Medical Waste Program?

☐ Primary Contact ☐ Secondary Contact ☐ Other Name: _____ Phone: _____

FACILITY TYPE (Check all that apply):

☐ Large Quantity Generator (greater than or equal to 200 lbs a month)

☐ Small Quantity Generator (less than 200 lbs per month)

☐ Skilled Nursing Facility or Convalescent Hospital

☐ Common Storage Facility (MWMA 117640). (Attach list of your clients and contact information.)

☐ My business will use someone else's Common Storage Facility (Fill out the information below if this box is checked.)

Facility Name: _____

☐ Other Describe: _____

MEDICAL WASTE ACTIVITIES (Check all that apply):

☐ Medical waste is shipped off site ☐ Medical waste is treated on site

☐ Some liquid or semi-liquid medical waste is sent to a sanitary sewer after disinfection (MWMA 118215c).

Has the local sanitary district been notified? ☐ Yes ☐ No Name of Sanitary District : _____

☐ Do you have a written procedure for this process? ☐ Yes ☐ No

Do you have a vivarium? ☐ Yes ☐ No If so, how do you handle your bedding and cages? Please describe below:

Do you store any of your medical waste in a freezer prior to shipment off site? ☐ Yes ☐ No

My facility has biosafety level labs ☐ BSL1 ☐ BSL2 ☐ BSL3 ☐ BSL4 ☐ N/A

My facility has a designated accumulation area (MWMA 118310) for our medical waste. ☐ Yes ☐ No

Location Description (e.g. room number): _____

Will any of your staff be generating medical waste in the field or away from your facility, thus warranting transporting medical waste back to your facility under the Materials of Trade Exemption (MWMA 117946 or 117976)?:

If yes, please attach your example log or documentation required. ☐ Yes ☐ No

Are you notifying the County at least 72 hours in advance before off site events, such as health fairs or vaccination clinics you are particpating in? (MWMA 117890, 117895)

TYPES OF REGULATED MEDICAL WASTE AND AMOUNTS PER MONTH (Answer all that apply)

Biohazardous	Disposal Amount:		Disposal Method:	
Sharps	Disposal Amount:		Disposal Method:	
Pathology	Disposal Amount:		Disposal Method:	
Trace Chemotheraputics	Disposal Amount:		Disposal Method:	
Pharmaceuticals*	Disposal Amount:		Disposal Method:	

If another treatment method is utilized, please list type of waste and method:

Are there any medical wastes you have determined non-infectious and dispose of it as non-regulated? ☐ Yes ☐ No

Waste Stream	Disposition	Written Justification
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

TYPES OF TREATMENT

Does this facility treat medical hazardous waste on site? ☐ Yes ☐ No

If yes, what treatment method(s) are utilized?: ☐ Steam Sterilization ☐ Incineration ☐ Microwave

☐ Other: Please specify:

If you autoclave medical waste on site please answer the following questions:

Do you have a written Standard Operating Procedure?: ☐ Yes ☐ No

Are you checking and recording treatment cycle temperatures?: ☐ Yes ☐ No

Are you performing monthly biological indicator testing to verify sterilization?: ☐ Yes ☐ No

This facility's total on site medical waste treatment capacity is _____ pounds per hour.

If you are treating (e.g. autoclaving) medical waste on site, please attach your written Closure Plan (MWMA 117935j or 117960j)

REGULATED OFF SITE TRANSPORTER INFORMATION

Company: Address: Suite or Unit:

City: State: Zip: Phone:

How do you verify rigid storage containers received from your transporters have been decontaminated properly? (MWMA 118295)

BACK UP OFF SITE TRANSPORTER INFORMATION

Company: Address: Suite or Unit:

City: State: Zip: Phone:

MAIL BACK PROGRAM

Do you utilize a mail back disposal program? ☐ Yes ☐ No Company: _____

Who is the Common Carrier utilized? ☐ USPS ☐ UPS ☐ FedEx ☐ Other List: _____

WASTE PHARMACEUTICALS

Describe how you segregate (RCRA vs. Non-RCRA), containerize, and label your waste pharmaceuticals:

Do you have a reverse distribution program for some of your pharmaceuticals?: ☐ Yes ☐ No If yes, who do you use?

SPILLS

How is your facility prepared to manage medical waste spills? (Describe, e.g. PPE, containerization, etc.):

TRAINING

Do your employees receive annual blood borne pathogen training? ☐ Yes ☐ N/A If N/A please describe why:

Are your employees trained on this Plan? ☐ Yes ☐ No

List other pertinent training and frequency of trainings related to medical wastes only:

Do you have a consultant assist you with management of the Program?: ☐ Yes ☐ No If yes, fill out the fields below:

Company: _____ Address: _____

Suite or Unit: _____ City: _____ State: _____ Zip: _____ Phone: _____

EMERGENCY ACTION PLAN (LQG's only) Describe actions or attach plan used:

☐ I hereby certify that the submitted information is true, accurate, and complete. I understand that an updated plan application will be required if this facility has any significant changes in the information included.

Signature of Owner/Agent or Representative: _____ Date: _____

OFFICE USE ONLY

Date Received: _____ ☐ Approved ☐ Approved with Agreed Changes

Additional Requirements: _____

Inspector Signature: _____ Date: _____