SAN MATEO COUNTY HEALTH
ENVIRONMENTAL HEALTH SERVICES

Environmental Health Services
Medical Waste Program
2000 Alameda de las Pulgas, Suite #100
San Mateo, CA 94403
Phone: (650) 372-6200 | Fax: (650) 627-8244
smchealth.org/medwaste | dacullen@smcgov.org

MEDICAL WASTE CLOSURE PLAN

FACILITY/CONTACT INFORMATION:

Facility Name: _____

Address: _____

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

Phone: _____ Fax: _____

Primary Contact: _____ Title: _____

Phone: _____ Email: _____

Secondary Contact: _____ Title: _____

Phone: _____ Email: _____

TYPE OF CLOSURE:

☐ Complete facility ☐ Partial facility ☐ Biohazardous process area ☐ Common storage facility

☐ On-site treatment unit. If so, type: _____

☐ Other (describe) _____

SCOPE OF WORK:

Brief Description:

PROPOSED SCHEDULE:

Proposed start date: _____ Duration of closure: _____

Proposed move out date: _____ ☐ N/A

TYPE OF MEDICAL WASTE GENERATED:

☐ Biohazardous (Red bag) ☐ Sharps ☐ Pathology ☐ Trace Chemotherapeutic waste ☐ Pharmaceutical waste

What are the primary infectious agents you will be decontaminating for?

Does this closure involve a vivarium or animal care facility? ☐ Yes ☐ No

This closure includes laboratories: ☐ BSL1 ☐ BSL2 ☐ BSL3 ☐ BSL4 ☐ N/A

DECONTAMINATION PROCESS:

What sanitizing agent will you be utilizing?

- ☐ Hypochlorite solution (500 ppm available chlorine)
- ☐ Phenolic solution (500 ppm active agent)
- ☐ Iodoform solution (100 ppm available iodine)
- ☐ Quaternary ammonium solution (400 ppm active agent)
- ☐ Other: (describe) _____

What areas or location will be decontaminated? (Attach a map)

PERSONNEL:

Who will be performing the decontamination and closure activities?

☐ Facility staff ☐ Contractor ☐ Other: (list) _____

What training has the closure personnel received that qualifies them?

DECONTAMINATION METHODOLOGY:

How will the decontamination activities be carried out (method)?

HEALTH AND SAFETY:

Do you have a written health and safety plan for this closure? ☐ Yes (please attach) ☐ No ☐ N/A

DISPOSAL:

How will the closure activity wastes be disposed of?

You must provide copies of any medical waste shipping documents to the County.

☐ **I hereby certify that the submitted information is true, accurate, and complete. I understand that before any changes are made to the plan I must notify the County.**

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

OFFICIAL USE ONLY

Date received: _____ ☐ Approved ☐ Approved with changes: _____

Additional requirements: _____

Inspector signature: _____ Date: _____