

NEW JERSEY REGULATED MEDICAL WASTE TRANSPORTER ANNUAL REPORT

(revised June 2016)

NEW JERSEY DEPARTMENT OF ENVIRONMENTAL PROTECTIONDivision of Solid and Hazardous Waste - Bureau of Recycling and Hazardous Waste Management
(609) 984-3438**I. TRANSPORTER IDENTIFICATION INFORMATION**

1. Reporting period 7/1/____ (previous year) to 6/30/____ (current year) Due 7/30/____ (current year)		
2. Transporter Name and Mailing Address _____ Name _____ Address _____ City, State, and Zip Code	3. NJDEP Medical Waste Identification Number _____	
4. Certification for Intermediate Transporter <input type="checkbox"/> Yes <input type="checkbox"/> No		
5. Contact Person		
_____	_____	(____) _____
Name (Please Print)	Title	Telephone Number
6. Certification		
<p>I certify that I have personally examined and am familiar with the information submitted in this and all attached documents, and based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate and complete.</p> <p>Name and official title of owner or owner's authorized representative</p>		
_____	_____	_____
Signature	Title	Date

II. DISPOSITION INFORMATION

7. Total Quantity of Regulated Medical Waste by Category and Destination (**NOTE: do not double count RMW (e.g. RMW reported as being delivered to a second transporter should <u>not</u> also be reported under the Destination Facility column. In that column only report RMW that was delivered by you <u>directly</u> to a destination facility.)		
	Second Transporter or Transfer Facility	Intermediate Handler or Destination facility
A. Untreated Waste (pounds)		
B. Treated Waste (pounds)		

III. GENERATOR IDENTIFICATION

8. Total Number of Generators From Whom Regulated Medical Waste was Accepted
 _____. (If your answer is "0", skip to Section IV)

9. Identity of Generators
 (Please complete Sections A, B, C, D and E for each Generator)

<p>A. Name and Location of Generator</p> <p>_____</p> <p>Name _____</p> <p>_____</p> <p>Address _____</p> <p>_____</p> <p>City, State, and Zip Code _____</p> <p>B. County code _____</p>	<p>C. Type of Generator _____</p> <p>If Other, Specify _____</p> <p>D. Quantity of Regulated Medical Waste Accepted from Generator</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p> <p>E. Generator Identification Number _____</p>
<p>A. Name and Location of Generator</p> <p>_____</p> <p>Name _____</p> <p>_____</p> <p>Address _____</p> <p>_____</p> <p>City, State, and Zip Code _____</p> <p>B. County code _____</p>	<p>C. Type of Generator _____</p> <p>If Other, Specify _____</p> <p>D. Quantity of Regulated Medical Waste Accepted from Generator</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p> <p>E. Generator Identification Number _____</p>
<p>A. Name and Location of Generator</p> <p>_____</p> <p>Name _____</p> <p>_____</p> <p>Address _____</p> <p>_____</p> <p>City, State, and Zip Code _____</p> <p>B. County code _____</p>	<p>C. Type of Generator _____</p> <p>If Other, Specify _____</p> <p>D. Quantity of Regulated Medical Waste Accepted from Generator</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p> <p>E. Generator Identification Number _____</p>
<p>A. Name and Location of Generator</p> <p>_____</p> <p>Name _____</p> <p>_____</p> <p>Address _____</p> <p>_____</p> <p>City, State, and Zip Code _____</p> <p>B. County code _____</p>	<p>C. Type of Generator _____</p> <p>If Other, Specify _____</p> <p>D. Quantity of Regulated Medical Waste Accepted from Generator</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p> <p>E. Generator Identification Number _____</p>

IV. SECOND TRANSPORTER AND TRANSFER FACILITY IDENTIFICATION

10. Total Number of Second Transporters and Transfer Facilities to which Regulated Medical Waste was Delivered _____. (If your answer is "0", complete Section V. If your answer is more than "0," then complete Section VI. Complete Section V if applicable or enter "0")

11. Identity of Second Transporter and Transfer Facilities
(Please complete Sections A and B for each Facility)

<p>A. Name and Location of <input type="checkbox"/> Second Transporter <input type="checkbox"/> Transfer Facility (Check one)</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State, and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Delivered to Second Transporter/Transfer Facility</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>
<p>A. Name and Location of <input type="checkbox"/> Second Transporter <input type="checkbox"/> Transfer Facility (Check one)</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State, and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Delivered to Second Transporter/Transfer Facility</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>
<p>A. Name and Location of <input type="checkbox"/> Second Transporter <input type="checkbox"/> Transfer Facility (Check one)</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State, and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Delivered to Second Transporter/Transfer Facility</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>
<p>A. Name and Location of <input type="checkbox"/> Second Transporter <input type="checkbox"/> Transfer Facility (Check one)</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State, and Zip Code</p>	<p>B. Quantity of Regulated Medical Waste Delivered to Second Transporter/Transfer Facility</p> <p>Untreated _____ pounds</p> <p>Treated _____ pounds</p>

V. INTERMEDIATE HANDLER AND DESTINATION FACILITY IDENTIFICATION

12. Total Number of Intermediate Handlers and Destination Facilities which Accepted Regulated Medical Waste for Disposal _____.
(If your answer is "0", do not continue with this Section)

13. Identity of Intermediate Handlers and Destination Facilities
(Please complete Sections A, B and C for each Facility)

A. Name and Location of
 Intermediate Handler
 Destination Facility (Check one)

 Name

 Address

 City, State, and Zip Code

B. Facility Type _____

C. Quantity of Regulated Medical Waste Delivered to Intermediate Handler/Destination Facility

Untreated _____ pounds

Treated _____ pounds

A. Name and Location of
 Intermediate Handler
 Destination Facility (Check one)

 Name

 Address

 City, State, and Zip Code

B. Facility Type _____

C. Quantity of Regulated Medical Waste Delivered to Intermediate Handler/Destination Facility

Untreated _____ pounds

Treated _____ pounds

A. Name and Location of
 Intermediate Handler
 Destination Facility (Check one)

 Name

 Address

 City, State, and Zip Code

B. Facility Type _____

C. Quantity of Regulated Medical Waste Delivered to Intermediate Handler/Destination Facility

Untreated _____ pounds

Treated _____ pounds

A. Name and Location of
 Intermediate Handler
 Destination Facility (Check one)

 Name

 Address

 City, State, and Zip Code

B. Facility Type _____

C. Quantity of Regulated Medical Waste Delivered to Intermediate Handler/Destination Facility

Untreated _____ pounds

Treated _____ pounds

VI. FINAL DISPOSAL FACILITY IDENTIFICATION

14. Total Number of Facilities which accepted Regulated Medical Waste for Disposal _____.
(Complete this section if you delivered waste to a second transporter or transfer facility and not directly to an intermediate handler or destination facility)

15. Identity of Final Disposal Facilities
(Please complete Sections A, B and C for each Facility)

A. Name and Location

 Name

 Address

 City, State, and Zip Code

B. Facility Type _____

C. Quantity of Regulated Medical Waste Accepted by the Final Disposal Facility
 Untreated _____ pounds
 Treated _____ pounds

A. Name and Location

 Name

 Address

 City, State, and Zip Code

B. Facility Type _____

C. Quantity of Regulated Medical Waste Accepted by the Final Disposal Facility
 Untreated _____ pounds
 Treated _____ pounds

A. Name and Location

 Name

 Address

 City, State, and Zip Code

B. Facility Type _____

C. Quantity of Regulated Medical Waste Accepted by the Final Disposal Facility
 Untreated _____ pounds
 Treated _____ pounds

A. Name and Location

 Name

 Address

 City, State, and Zip Code

B. Facility Type _____

C. Quantity of Regulated Medical Waste Accepted by the Final Disposal Facility
 Untreated _____ pounds
 Treated _____ pounds