CONTRA COSTA HEALTH SERVICES

CONTRA COSTA
ENVIRONMENTAL HEALTH DIVISION
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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 (check one):

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

SECTION 3: Contact Information

(Owner/Permit Holder Address and Facility Address must be different addresses)

A. Owner / Permit Holder Information

(If marking an ownership type, please provide proof)

OWNER / PERMIT HOLDER NAME:	☐ INC ☐ LLC ☐ LP ☐ 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 4: 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: ❑ CASH ❑ CHECK ❑ CREDIT CARD			RECEIPT #: XR