COUNTY OF MARIN
ENVIRONMENTAL HEALTH SERVICES
3501 CIVIC CENTER DRIVE, RM 236
SAN RAFAEL, CA 94903
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www.marincounty/ehs

COUNTY OF MARIN

COMMUNITY DEVELOPMENT AGENCY
ENVIRONMENTAL HEALTH SERVICES DIVISION

Medical Waste Application

Business/Generator's Name _____

Contact Person & Title _____

Business Address _____

Phone_____ Email Address_____

Type of business (Please include a description) _____

Types and estimated **maximum** quantity of medical waste generated **per month**

- ☐ Sharps (needles, syringes, syringes contaminated with biohazardous waste, acupuncture needles, root canal files, or any other device capable of cutting or piercing) — Quantity (lbs)_____
- ☐ Biohazardous (fluid blood products, infectious secretions, laboratory waste, surgery specimens, animal parts or animal fluids contaminated with infectious agents known to be contagious to humans) — Quantity (lbs)_____
- ☐ Chemotherapeutic Agent (or Radioactive waste...e.g., waste from cancer therapies and medical equipment that uses radioactive material) — Quantity (lbs)_____
- ☐ Pharmaceuticals (prescription or over-the-counter human or veterinarian drug, including, but not limited to, drug as defined in Section 109925 or the Federal Food, Drug and Cosmetic Act as amended (21 U.S.C.A Sec. 321 (g)(1)) — Quantity (lbs)_____

Medical Waste Disposal Method:

☐ Common Storage Facility ☐ Approved Hauler ☐ Mailback ☐ Other: _____

If using certified hauler, please provide company name: _____

Frequency of disposal or pick-up: _____

Certification: The undersigned hereby applies for a Medical Waste Generator Permit from the County of Marin. I hereby certify that the submitted information is true, accurate, and complete. I understand that a new application will be required if this facility changes ownership, moves, or begins generating wastes which are not listed on this application.

Signature of Owner/Operator, Agent or Representative: _____

Title: _____ Date _____