CONTRA COSTA
ENVIRONMENTAL HEALTH DIVISION
2120 DIAMOND BOULEVARD, SUITE 100
CONCORD, CA 94520
(925) 608-5500 PHONE | (925) 608-5502 FAX
http://www.cchealth.org/eh
medical.waste@cchealth.org

MEDICAL WASTE PROGRAM APPLICATION

(ONLY $45 APPLICATION FEE IS DUE AND NON-REFUNDABLE, PERMIT FEES WILL BE INVOICED SEPARATELY)

SECTION 1: Type of Application:

- ○ New Facility
- ○ Change of Facility Ownership
- ○ Change of Facility Name
- ○ Change of Accounts Receivable Info

SECTION 2: Type of Facility (Check One, **Requires a Medical Waste Management Plan):

- ○ 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: Facility Information

(Permit Holder Address and Facility Address must be different, Old Ownership section only needed if there was an existing permit) **(If marking an ownership type, please provide proof)**

Permit Holder	PERMIT HOLDER NAME:		☐ INC ☐ LLC ☐ LP ☐ CORP
	PERMIT HOLDER MAILING ADDRESS:		
	CITY / STATE / ZIP CODE:	PHONE #:	FAX #:
Facility	FACILITY NAME / DBA:		
	FACILITY ADDRESS:		
	CITY / STATE / ZIP CODE:	PHONE #:	FAX #:
	FACILITY EMAIL:		
Billing	IN CARE OF (Billing Office or Person in Charge):		
	ACCOUNTS RECEIVABLE ADDRESS:		
	CITY / STATE / ZIP CODE:	PHONE #:	FAX #:
Old Ownership	PREVIOUS PERMIT HOLDER NAME:		☐ INC ☐ LLC ☐ LP ☐ CORP
	PREVIOUS PERMIT HOLDER MAILING ADDRESS:		
	CITY / STATE / ZIP CODE:	PHONE #:	FAX #:

SECTION 4: Medical Waste Approved Hauler, Mailback System, or Alternative Treatment System Information

(All medical waste must be disposed of via a California Department of Public Health approved medical waste transporter)

HAULER / MAILBACK / ALTERNATIVE TREATMENT SYSTEM NAME:

SECTION 5: 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 ☐ CREDIT CARD			RECEIPT #: XR