Sanitation

ENVIRONMENTAL POLICE UNIT
465 Hamilton Avenue
Brooklyn, New York 11232
Telephone (212) 437-4452
Fax(212)437-4599

Annual 2024
SOLID WASTE REMOVAL PLAN

ANNUAL FILING DATE_____

GENERATOR INFOMATION

GENERATOR NAME (NO ABBREV.)_____
EIN NUMBER_____
STREET_____
CITY _____ STATE_____ ZIPCODE_____
COUNTY_____
EMAIL ADDRESS_____

INSTITUTION

☐ **CITY** ☐ **STATE** ☐ **FEDERAL** ☐ **PRIVATE -PROFIT** ☐ **PRIVATE - NONPROFIT**

CONTACT PERSON

NAME_____

TITLE _____ **TEL NO.** (_____) _____

TYPE OF GENERATOR

☐ HOSPITAL
☐ VETERINARY CLINIC
☐ NURSING HOME
☐ MEDICAL DOCTOR
☐ ACUPUNCTURE
☐ LABORATORY
☐ PRIVATE CLINIC
☐ DENTIST
☐ PODIATARY
☐ OTHER

(DESCRIBE OTHER) _____

PLEASE ATTACH A LIST OF ALL SATELLITE FACILITIES AND COMPLETE SEPARATE SOLID WASTE REMOVAL PLAN FOR EACH

TYPE OF REGULATED MEDICAL WASTE GENERATED

(CHECK ALL THAT APPLY)

- ☐ ISOLATION WASTE
- ☐ SHARPS
- ☐ HUMAN BLOOD/ BLOOD PRODUCTS
- ☐ CONTAMINATED ANIMAL CARCASSES
- ☐ DIALYSIS WASTE
- ☐ LABORATORY WASTE
- ☐ HUMAN PATHOLOGICAL WASTE
- ☐ CULTURES AND STOCKS OF INFECTIOUS AGENTS
- ☐ WASTE FROM SURGERY OR AUTOPSY

GENERATOR WASTE INFORMATION

A. APPROXIMATE QUANTITY OF REGULATED MEDICAL WASTE GENERATED AT THIS ADDRESS.

LBS/MONTH _____

B. APPROXIMATE QUANTITY OF SOLID WASTE (REG. GARBAGE) GENERATED AT THIS ADDRESS.

CUBIC YDS/MONTH _____

C. AMOUNT OF REGULATED MEDICAL WASTE RECEIVED FROM OUTSIDE SOURCES.

EX. DOCTOR OFFICES, ANNEX

_____

_____

_____

_____

_____

REGULATED MEDICAL WASTE TRANSPORTER

CONTACT INFORMATION

TRANSPORTER NAME (NOABBREY.)_____

STREET_____

CITY _____STATE_____ ZIP CODE _____

CONTACT PERSON _____TEL NO. (____) _____

DEC PERMIT NO. _____

DISPOSAL SITE

CARTER'S NAME (NOABBREV.)_____

STREET_____

CITY_____ STATE_____ ZIP CODE_____

TEL NO. (_____)_____

IMPORTANT NOTICE

PLEASE ENCLOSE A COPY OF YOUR MOST RECENT

MEDICAL WASTE TRACKING FORM

(DISPOSAL FACILITY SIGNATURE COPY)

DISPOSAL OF SOLID WASTE

(REGULAR TRASH)

CONTACT INFORMATION

CARTER'S NAME (NOABBREV.)_____

CITY_____ STATE _____ ZIPCODE_____

CONTACT PERSON_____ TEL NO. (____)_____

BUSINESS INTEGRITY COMMISSION NO. (BIC)_____

DISPOSAL SITE

NAME (NO ABBREV.) _____

STREET _____

CITY _____ STATE _____ZIP CODE _____

TEL NO. ( )_____

CERTIFICATION

I certify that I have personal knowledge of the information submitted in this document. And this information is true, accurate, and complete.

PLEASE PRINT NAME AND OFFICIAL TITLE OF OWNER, OWNER'S AUTHORIZED REPRESENTATIVE, OR PERSON IN CHARGE.

NAME _____

TITLE _____

DATE _____

SIGNATURE _____

REMINDER

PLEASE ENCLOSE A COPY OF YOUR MOST RECENT
MEDICAL WASTE TRACKING FORM
(MANIFEST)
(DISPOSAL FACILITY SIGNATURE COPY)

NOTE: NOT SUBMITTING A TRACKING FORM (MANIFEST) OR NOT COMPLETING ALL REQUESTED INFORMATION WILL BE CONSIDERED AS A (NON) FILED SOLID WASTE REMOVAL PLAN.

SEND COMPLETED FORM TO:

NEW YORK CITY DEPARTMENT OF SANITATION
ENVIRONMENTAL POLICE UNIT
465 HAMILTON AVENUE
BROOKLYN, NEW YORK
11232