



Medical Waste Management Program TRAUMA SCENE WASTE MANAGEMENT PRACTITIONER (TSWMP) APPLICATION

For Renewals: TSWMP # _____

Date of Application: _____

Company Name	WEB Address	Number of Vehicles Used to Transport Waste <input style="width: 30px; height: 20px;" type="text"/>			
Mailing Address	City	State	ZIP Code	Phone Number ()	Fax Number ()
Physical Address	City	State	Zip Code	Phone Number ()	Fax Number ()
Owner Name	Phone Number ()	Email			
Contact Name	Phone Number ()	Email			
Place of business utilized for medical waste storage: <input type="checkbox"/> Yes <input type="checkbox"/> No			Utilizing medical waste mail-back system: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Number of freezers utilized for medical waste storage on premises: <input style="width: 30px; height: 20px;" type="text"/>					

Medical Waste Transporter Information – Use additional sheets if necessary

Hauler ID	Company Name	Telephone Number	Address

Provide information on the medical waste transfer station and/or treatment facility used.

TS/TSOST ID	Facility Utilized	Facility Address (City/State/ZIP code)	Off-Site Treatment	Transfer Station
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

REQUIRED DOCUMENTS:

- ✓ A copy of the current year service agreement with hauler(s), transfer station(s), off-site treatment facility(s), or mail-back system invoice.
- ✓ \$200 check (made out to **Medical Waste Management Fund**) for renewal and initial application fee.

Mail to:

**California Department of Public Health
Medical Waste Management Program
MS 7405 P.O. Box 997377
Sacramento, CA 95899-7377**