Medical Waste Management Program

Medical Waste Transporter Annual Verification

Company

Company Name:			
Number of Vehicles used to transport waste:			
DTSC Transporter Registration Number:		Expiration Date:	
Facility Contact Person:		Telephone Number:	
Email:			
Street Address:			
City:	County:	State:	Zip Code:
Mailing Address:			
City:		State:	Zip Code:
Web Address (optional):			

Type of Waste Collected and Estimation of Pounds

Sharps	Biohazardous Red Bag	Pharmaceutical	Pathology	Trace Chemotherapy	Trauma Scene Waste

Medical Waste Facility

TS/TS-OST ID	Permitted Facility Utilized or Mail-back Information	Facility Address (City/State/ZIP code)	Off-Site Treatment	Transfer Station
			☐Yes	☐Yes
			☐Yes	☐Yes

Certification

I certify under penalty of perjury that the information contained in this application is true and accurate to the best of my knowledge and belief.

Authorized Representative:	Title:
Signature:	Date:

Requested Documents:

- ✓ A current sample of the medical waste tracking document.
- ✓ A current copy of the DTSC Hazardous Waste Transporter Registration certificate.

Email this completed form and the requested documents to MedWasteTransporter@cdph.ca.gov