



## California Medical Waste Management Program MEDICAL WASTE TRANSPORTER ANNUAL VERIFICATION FORM

Company Name			DTSC Transporter Registration Number						
Physical Address			Expiration Date						
City, State	Zip Code	County	Owner Name						
Telephone	Fax		Owner Phone ( )						
Mailing Address			Owner Email						
City, State	Zip Code	County	Facility Operator Name						
Telephone ( )	Fax ( )	Web Address	Operator Phone ( )						
<b>Vehicle Information</b> <b>Website Listing Information</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Number of Vehicles</td> <td style="width: 15%;"></td> <td rowspan="2">Please select which address you want listed on the Department's website:   <input type="checkbox"/> Physical      <input type="checkbox"/> Mailing                 </td> </tr> <tr> <td>Number of Trailers</td> <td></td> </tr> </table>			Number of Vehicles		Please select which address you want listed on the Department's website:  <input type="checkbox"/> Physical <input type="checkbox"/> Mailing	Number of Trailers		Operator Email	
			Number of Vehicles			Please select which address you want listed on the Department's website:  <input type="checkbox"/> Physical <input type="checkbox"/> Mailing			
Number of Trailers									
			Contact Person						
			Contact Phone ( )						
			Contact Email						

### Type of Waste Collected and Estimation of Pounds

Sharps	Biohazardous Red Bag	Pharmaceutical	Pathology	Trace Chemotherapy	Trauma Scene Waste

### Provide information on the medical waste transfer station and/or treatment (TS/TSOST) facility used.

Facility Utilized	Facility Contact Information	Off-Site Treatment	Transfer Station
	Permit Number	Check if yes: <input type="checkbox"/>	Check if yes: <input type="checkbox"/>
	Address		
	City, State, Zip Code		
	Telephone ( )	Check if yes: <input type="checkbox"/>	Check if yes: <input type="checkbox"/>
	Permit Number		
	Address		
	City, State, Zip Code	Check if yes: <input type="checkbox"/>	Check if yes: <input type="checkbox"/>
	Telephone ( )		

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

Authorized Representative	Title
Signature	Date

#### REQUIRED DOCUMENTS:

- ✓ A copy of the DTSC Hazardous Waste Transporter Registration certificate.
- ✓ A copy of the service agreement(s) with the transfer station and/or off-site treatment facility.
- ✓ A sample medical waste tracking document.

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

\*On or before July 1<sup>st</sup> of each year, a registered hazardous waste hauler that transports medical waste shall provide the Department with the required information per CA Health and Safety Code (HSC), Section 118029(a). Use form CDPH 8668, Annual Verification Form.

\*Quarterly provide the Department with a list of all medical waste generators serviced, including those contracted by another company. [HSC Section 118029 (b)]. See form CDPH 8666.