Appendix I to 40 CFR Part 259—Medical Waste Tracking Form and Instructions

State Information Block (Name, Address, Contacts, Phone Numbers, etc.)

State Tracking Form Number (if applicable)

Medical Waste Tracking Form

GENERATOR

1. **Generator's Name and Mailing Address**

2. **Tracking Form Number**

3. **Telephone Number** ( )

4. **State Permit or ID No.**

5. **Transporter's Name and Mailing Address**

6. **Telephone Number** ( )

7. **State Transporter Permit or ID No.**

EPA Med. Waste ID No.

8. **Destination Facility Name and Address**

9. **Telephone Number** ( )

10. **State Permit or ID No.**

11. US EPA Waste Description	12. Total No. Containers	13. Total Weight or Volume
a. Regulated Medical Waste (Untreated)		
b. Regulated Medical Waste (Treated)		
c. State Regulated Medical Waste		

14. **Special Handling Instructions and Additional Information**

15. **Generator's Certification:**

Under penalty of criminal and civil prosecution for the making or submission of false statements, representations, or omissions, I declare on behalf of the generator that the contents of this consignment are fully and accurately described above and are classified, packaged, marked and labeled in accordance with all applicable State and Federal laws and regulations, and that I have been authorized in writing to make such declaration by the person in charge of the generator's operation.

Printed/ Typed Name Signature Date

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING MEDICAL WASTE TRACKING FORM

Copy 1 — GENERATOR COPY: Mailed by Destination Facility to Generator
Copy 2 — DESTINATION FACILITY COPY: Retained by Destination Facility
Copy 3 — TRANSPORTER COPY: Retained by Transporter
Copy 4 — GENERATOR COPY: Retained by Generator

As required under 40 CFR Part 259:

1. This multi-copy (4-page) shipping document must accompany each shipment of regulated medical waste generated in a Covered State.
2. Items numbered 1-14, must be completed before the generator can sign the certification. Items 4, 7, 10, 11c, & 19 are optional unless required by the State. Item 22 must be completed by the destination facility.

For assistance in completing this form, contact your nearest State office, Regional EPA office, or call (800) 424-9346.

TRANSPORTER

16. **Transporter 1** (Certification of Receipt of Medical Waste as described in items 11, 12 & 13)

Printed/ Typed Name Signature Date

17. **Transporter 2 or Intermediate Handler** (name and address)

18. **Telephone Number**

19. **State Transporter Permit or ID No.**

EPA Med. Waste ID No.

20. **Transporter 2 or Intermediate Handler** (Certification of Receipt of Medical Waste as described in items 11, 12 & 13)

Printed/ Typed Name Signature Date

21. **New Tracking Form Number** (for consolidated or remanifested waste)

DESTINATION

22. **Destination Facility** (Certification of Receipt of Medical Waste as described in items 11, 12 & 13)

☐ Received in accordance with items 11, 12 & 13

Printed/ Typed Name Signature Date

(If other than destination facility, indicate address, phone, and permit or ID no. in box 14.)

23. **Discrepancy Box** (Any discrepancies should be noted by item number and initials)

BILLING CODE 6560-50-C

General Instructions

Read all instructions before completing this form.

This form has been designed for use on a 12-pitch elite typewriter; a firm ballpoint pen may also be used—press down hard (as you are writing through multiple copies).

Federal regulations require generators, transporters, intermediate handlers, and owners and operators of destination facilities (treatment, destruction facilities, and disposal facilities) to use this form for both inter- and intrastate transportation of regulated medical waste which is generated in a Covered State. Generators must obtain the Medical Waste Tracking Form from the following sources:

(1) If the regulated medical waste is to be shipped to a Covered State for treatment, destruction, or disposal, then the generator must use that Covered State's form. For generators who transport or offer for transport regulated medical waste to another Covered State which requires use of its version of the tracking form, the transporter must provide the generator with the receiving Covered State's form.

(2) If the receiving Covered State does not require the use of its version of the form, or the receiving State is a non-Covered State, then the generator must obtain the form from the generator's own State.

(3) If the generator's State does not require the use of that State's version of the tracking form, then the generator may obtain copies from other sources or produced them using the printed version of the Federal form provided in this appendix.

Section 11007 of the Medical Waste Tracking Act specifies that any State or local law which requires submission of a regulated medical waste tracking form from any person subject to this Act shall require that the form be identical in content and format to the Medical Waste Tracking Form except that a State may require the submission of other information which is supplemental to that on the form. Such State-required information may be included through use of additional sheets or such other means as the State deems appropriate. The Agency determines that no additional or supplemental State information can be required on the form except as specified below. Generators of regulated medical waste in Covered States are advised to be aware of any special requirements within the Covered States.

If States wish to print their own forms, they may print in the one inch box at the top of the form the following types of information: (1) Where to obtain a State printed tracking form; (2) essential State information (State addresses or telephone numbers); and (3) special State instructions (e.g., if the State requires a five or six part form, that State might print addresses to which the additional forms must be sent).

The Medical Waste Tracking Form also includes a box for a State Tracking Form Number. If the State requires such a number, it can be printed on the form in that box. In addition, some States may require waste identification or waste authorization numbers. These numbers can be entered by the generator in box 11 (a-c). In addition, States may require generators to use box 11(c) to identify medical waste regulated under State law but not under Federal law.

Federal regulations require generators, transporters, intermediate handlers, and destination facilities to complete the form according to the following instructions.

Medical Waste Tracking Form Specific Instructions

The following describes each section of the Medical Waste Tracking Form and provides instructions for completing each of these sections (i.e., boxes). The waste generator completes Boxes 1–15, the transporter and/or intermediate handlers completes Boxes 16–21, and the owner or operator of the destination facility completes Boxes 22–23. The transporter may assist the generator in completing any of the boxes, but the generator is responsible for ensuring the accuracy of information entered on the form and *must* sign Box 15 after Boxes 1–14 are completed.

Box 1. *Generator's Name and Mailing Address.* Enter the name and mailing address of the generator. The mailing address should be the address to which intermediate handler or the destination facility will return the signed copy of the tracking form, and should be for the location where the generator's tracking forms will be handled for purposes of recordkeeping and exception reporting (e.g., the company's billing office, corporate headquarters, or the actual site of generation).

While the address entered here need not identify the particular site of generation, the generator must maintain its records so that individual waste shipments (identified by a unique tracking form document number assigned by the generator, discussed next) can be associated with the actual sites of generation.

Box 2. *Tracking Form Number.* This is the unique number that the generator must assign to each shipment of regulated medical waste. It will ensure that each individual shipment can be identified and independently tracked from the site of generation. [The number could be the date of shipment or some other notation that the generator wishes to utilize.]

Box 3. *Telephone Number.* Enter the telephone number for the generator representative who can provide additional information about the shipment in the event of an emergency, or in the event the transporter, intermediate handler or destination facility requires it for other reasons (e.g., to inform the generator that an alternative disposal facility must be used).

Box 4. *State Permit or ID Number.* This is an *optional* entry, except when required by State law. Some States may assign a number or alphanumeric designation to uniquely identify each generator, and may require that the generator include this designation on each medical waste tracking form it initiates.

Box 5. *Transporter's Name, Mailing Address and EPA Medical Waste Identification Number.* Indicate in this space the name and address of the regulated medical waste transporter who will be the first transporter of the waste listed on the tracking form. The mailing address should be the business mailing address of the transporter. The transporter must fill in his EPA Medical Waste Identification Number for the State in which the waste was generated. If a number has not yet been assigned, the transporter must leave this box blank. The EPA Medical Waste Identification Number is assigned by EPA when the transporter notifies EPA.

Box 6. *Telephone Number.* Enter the telephone number of the transporter that the generator, intermediate handler or destination facility may call to obtain information regarding medical waste shipments.

Box 7. *State Transporter Permit or ID Number.* This is an optional entry to be utilized where States have assigned permit or identification numbers to each medical waste transporter and require that designation to be recorded on each tracking form. The number should be the permit or identification number used by the State in which the regulated medical waste was generated.

Box 8. *Destination Facility Name and Address.* The generator must enter the name and site address of the off-site destination facility (i.e., treatment and destruction or disposal facility) that the generator has specified to receive the regulated medical waste. The site address is necessary to inform the transporter where the shipment must be delivered. (If the generator does not have this information, the transporter may complete this section, but only before the generator signs the form. Transfer facilities and other temporary storage facilities used by transporters for storage of waste during ordinary transport must not be listed here as the destination facility.) Intermediate handlers used by the generator or transporter to either treat or destroy the waste (but not both) must not be listed here either.

Box 9. *Telephone Number.* Enter the destination facility's telephone number which a generator or transporter may call to obtain information regarding the status of a shipment.

Box 10. *State Permit or ID Number.* This is an *optional* box which must be filled out if this information is required by the State in which the destination facility is located. States may require that destination facility (i.e., treatment and destruction or disposal facilities) be permitted and they may require that a State-assigned unique permit or identification number be entered in this space.

Box 11. *U.S. EPA Waste Description.* The two Federally-regulated medical waste categories are listed in Boxes 11(a) and 11(b): Regulated Medical Waste (untreated); Regulated Medical Waste (treated). Box 11(c) is available for other State regulated waste. The generator must determine the categories of his waste, before completing Boxes 12 and 13. A definition of "waste category" is found in 40 CFR 259.10. [If States have a waste code, a waste authorization number, or a similar requirement, it may be inserted to the right of the waste category to which it applies.]

Box 12. *Total Number Containers.* The total number of containers (e.g., bags, boxes, pails, drums, etc.) for each of the applicable waste categories must be entered in the corresponding space.

Box 13. *Total Weight or Volume.* The total weight of the waste (excluding the container

weight), by applicable waste category must be entered in the corresponding space. If the waste is oversized and is not packaged in a standard container, a volumetric measure may be used; however, the unit of measure must be noted in that space as well.

Box 14. *Special Handling Instructions and Additional Information.* Generators may use this space to indicate special transportation, treatment, storage, or disposal information or Bill of Lading information, including alternative treatment and/or disposal facility information, if necessary. Generators may also include in this box a written request for the destination facility to certify disposal of the regulated medical waste through signature and dating within this box. (Note: The signature in the Destination Facility Certification Box (Box 22) is *only* to be used to certify receipt of the waste at the time of delivery to the facility.)

For international shipments, generators must enter in this space the point of departure (city and State) for those wastes destined for treatment and destruction, or disposal outside the United States. This space may also be used if there is need to identify an intermediate handler and/or a third transporter. States may not require additional information to be provided in this space on the tracking form. However, other State-specific information requirements may be included on a separate, attached sheet.

This space should also be used to provide special instructions or additional information regarding oversized regulated medical waste that cannot be easily packaged in plastic bags or standard containers. In these instances, enter a description of the waste including whether the waste is untreated or treated, the number of pieces, and the approximate total weight.

Box 15. *Generator's Certification.* This statement, when signed by the generator, certifies that all information required to be provided by that generator is accurate (including any information provided by the transporter in Boxes 1–14), all documented wastes are properly prepared for transport and all applicable State and Federal requirements have been met. The generator must read, sign by hand, date this certification statement and enter the name of the generator into the certification statement. The persons signing the statement must be authorized to make the required declarations, in writing, by the person in charge of the generator's operations. The generator must make certain that Boxes 1–14 (except Boxes 4, 7, 10, and 11(c), which are optional unless required by the State) are completed prior to signing the form.

Box 16. *Transporter 1 Certification of Receipt.* The first transporter is required to acknowledge the acceptance of the waste shipment from the generator by signing the form in this space and recording the date of acceptance. Any discrepancies or other related information should be noted in the Discrepancy Box (Box 23) of the tracking form before signing it. In those instances when a transporter initiates a tracking form, he must complete Boxes 1–15 and must also certify receipt as transporter 1, if he is also the first transporter as identified in Box 5 (Transporter's Name and Mailing Address).

Box 17. *Transporter 2 or Intermediate Handler Name and Address, and EPA Medical Waste Identification Number.* In the event the waste shipment is to be transported by a second transporter or is taken to an intermediate handler, that recipient must enter its name and business mailing address information in this place, and their EPA Medical Waste Identification Number, if available.

Box 18. *Telephone Number.* Enter the telephone number of the second transporter or intermediate handler to be used when checking or investigating the status of a shipment.

Box 19. *State Transporter Permit or ID Number.* This is an *optional* entry. The secondary transporter or intermediate handler State-assigned permit or identification number should be entered in this space (see number 7 above).

Box 20. *Transporter 2 or Intermediate Handler Certification of Receipt.* A secondary transporter or intermediate handler is required to certify acceptance of the waste shipment by printing or typing the name of the person accepting the waste, recording the date of acceptance, and signing the form. Any discrepancies or other related information should be noted in the Discrepancy Box (Box 23) of the tracking form before signing this box.

Box 21. *New Tracking Form Number.* If the regulated medical waste shipment is consolidated or reassigned to a new tracking form, the new tracking form number must be recorded in this box on the original generator's form. (If the Covered State preprints forms and includes a State Tracking Form Number, that number should be entered in this space.) If the State does not include a preprinted number on the form the transporter or intermediate handler should enter its own unique tracking form number.

Box 22. *Destination Facility.* The authorized representative of the destination facility certifies receipt and acceptance of the shipment on behalf of the owner of the facility by completing this box. If no discrepancies are noted, the authorized representative should place a checkmark before the statement "received in accordance with items 11, 12, and 13," print or type his name, record the date of acceptance, and sign the box. If there are any discrepancies he should *not* place a check there. He should, instead, note the discrepancies in Box 23.

If for some reason the regulated medical waste was delivered to a facility other than that indicated in Box 8, then the authorized representative of the facility that accepted the waste completes Box 22, as indicated above, enters in Box 14 the name, address, telephone number and the facility permit or identification number, if any, of the facility accepting the waste.

Box 23. *Discrepancy Box.* The authorized representative of the destination (or alternate) facility, on behalf of the owner or operator, must note any discrepancy between the waste described on the tracking form and the waste actually received at the facility. (Note: in some instances, due to the consolidation or remanifesting provisions of this part, transporters and intermediate handlers may also need to record discrepancies.) All discrepancies must be noted by inclusion in Box 23. Owners and operators of facilities who cannot resolve discrepancies within 15 days of receiving a waste shipment must file a discrepancy report as required in 40 CFR 259.82. Discrepancy reports must be submitted to the appropriate State agencies and to the appropriate EPA Regional offices, as required in § 259.82 of this part. EPA Regional office addresses are listed below.

EPA Regional Administrators

Regional Administrator, U.S. EPA Region I, J.F. Kennedy Federal Building., Boston, MA 02203

Regional Administrator, U.S. EPA Region II, 26 Federal Plaza, New York, NY 10278

Regional Administrator, U.S. EPA Region III, 5th and Walnut Streets, Philadelphia, PA 19106

Regional Administrator, U.S. EPA Region IV, 345 Courtland Street, NE, Atlanta, GA 30365

Regional Administrator, U.S. EPA Region V, 230 S. Dearborn Street, Chicago, IL 60604

Regional Administrator, U.S. EPA Region VI, 1201 Elm Street, Dallas, TX 75270

Regional Administrator, U.S. EPA Region VII, 324 East 11th Street, Kansas City, MO 64106

Regional Administrator, U.S. EPA Region VIII, 1860 Lincoln Street, Denver, CO 80295

Regional Administrator, U.S. EPA Region IX, 215 Fremont Street, San Francisco, CA 94105

Regional Administrator, U.S. EPA Region X, 1200 Sixth Avenue, Seattle, WA 98101

BILLING CODE 6560-50-M

Appendix II to Part 259—On-Site Medical Waste Incinerator Report and Instructions

Page 1 of ____

ON-SITE MEDICAL WASTE INCINERATION REPORT

I. FACILITY INFORMATION

1. Reporting Period

☐ June 22, 1989 to December 22, 1989

☐ June 22, 1990 to December 22, 1990

2. Facility Name and Mailing Address

Facility Name

Mailing Address

City State Zip Code

3. Location of Incineration Facility

☐ Address of location is the same as mailing address in Box 2.

or

Street Address

City State Zip Code

4. Type of Facility

☐ Hospital ☐ Laboratory Facility ☐ Veterinary Clinic ☐ Private Practice or Clinic

☐ Funeral Home/Crematorium ☐ Other (Specify,_____)

5. Contact Person at Facility

Name Title (___)_____ Telephone Number

6. Waste Feed Information (total for all incinerators specified in Box 7)

A. Approximate Total Quantity of Regulated Medical Waste Incinerated: | | | | | | | | | | Pounds/six-month reporting period

B. Approximate Percentage of Total Waste Incinerated that is Regulated Medical Waste | | | | %

C. Approximate Quantity of Regulated Medical Waste Received from Sources Outside this Facility: | | | | | | | | | | Pounds/six-month reporting period

Facility Name_____ Page ____ of ____

II. INCINERATION INFORMATION

7. Total Number of Incinerators that Incinerate Regulated Medical Waste at this Facility:

|_|_|_|

8 a. Incinerator Design Information

A. Age of Incineration unit: |_|_| Years

B. Type of Unit:
- ☐ Excess Air
- ☐ Starved Air
- ☐ Rotary Kiln
- ☐ Other (Specify, _____)

C. Number of Combustion Chambers:
- ☐ One Chamber
- ☐ Two Chambers
- ☐ Three or more Chambers

D. Design Charging Capacity: |_|_|_|_|_|_| Pounds per hour

8 b. Incinerator Design Information

A. Age of Incineration unit: |_|_| Years

B. Type of Unit:
- ☐ Excess Air
- ☐ Starved Air
- ☐ Rotary Kiln
- ☐ Other (Specify, _____)

C. Number of Combustion Chambers:
- ☐ One Chamber
- ☐ Two Chambers
- ☐ Three or more Chambers

D. Design Charging Capacity: |_|_|_|_|_|_| Pounds per hour

9. Certification

I certify that I have personally examined and am familiar with the information submitted in this and all attached documents, and that based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate, and complete.

Name and official title of owner or owner's authorized representative.

_____ _____ _____

Name Title Date

BILLING CODE 6560-50-C

General Instructions

Authority

This information is required by EPA under the authorities of sections 11003 and 11004 of the Resource Conservation and Recovery Act. EPA expects that you will provide this information based on reasonably available records, or, in the absence of such records, on your knowledge.

Who Must Complete This Form?

This form must be completed by generators of regulated medical waste who:

- Are located in Covered States; and
- Use an on-site incinerator to burn regulated medical waste during the reporting periods described below.

Only complete this form for incinerators that burn regulated medical waste. Refer to 40 CFR 259.61 for recordkeeping requirements pertaining to this reporting form.

When to Complete This Form?

Generators who incinerate regulated medical waste on-site are required to submit the On-site Medical Waste Incinerator Report to EPA for two separate reporting periods.

The first report covers the period from June 22, 1989, to December 22, 1989. The submission date for the first reporting period is February 6, 1990.

The second report covers the period from June 22, 1990, to December 22, 1990. The submission date for the second reporting period is February 6, 1991.

Where to send this Report?

In each reporting period, submit two copies to: Chief, Waste Characterization Branch, Office of Solid Waste (OS-332), U.S. Environmental Protection Agency, 401 M Street SW., Washington, DC 20460.

Instructions for Completing the Form

Boxes 1 through 5 require general information about the facility. Boxes 6 through 8 require specific information about the waste incinerated and technical information regarding the incinerators themselves. Box 9 requires the facility owner or operator to certify the accuracy of the information submitted. Begin with Box 1 and continue sequentially to each box. If there is more than one on-site incinerator used to incinerate regulated medical waste, complete Box 8(a) for the first incinerator and Box 8(b) for the second incinerator; for more than two incinerators, you will need to use an additional sheet(s) to provide the required incinerator information.

You will also need to sign the certification Box (Box 9) on each additional sheet.

Box 1. *Reporting Period.* Mark an "X" in the box that specifies the reporting period for the information you are submitting.

Box 2. *Facility Name and Mailing Address.* Enter the name and mailing address of the incineration facility.

Box 3. *Location of Incineration Facility.* If the location address of the incineration facility is the same as the mailing address entered in Box 2, mark an "X" in the designated box. If the location address is different from the mailing address, enter the location information.

Box 4. *Type of Facility.* Mark an "X" in the box that classifies the business or organization that owns or operates the incineration facility. If the categories do not accurately represent your facility, mark the "Other" category and specify the facility type in the space provided.

Box 5. *Contact Person at the Facility.* Enter the name, title, and telephone number of the person who is most knowledgeable about the incineration operations at your facility.

Box 6. *Waste Feed Information.* The questions in this box ask about quantities of regulated medical waste incinerated at your facility. When entering a response, right justify the entry (e.g., | | |2 |0 |0 |0 |0 | Pounds).

A. *Approximate Total Quantity of Regulated Medical Waste Incinerated.* Enter the total weight (in pounds) of the regulated medical waste incinerated at your facility (total of all incinerator units) during the six-month reporting period. To identify the quantities of regulated medical waste incinerated, refer to the operating logs kept for each incinerator at your facility as required under 40 CFR 259.61.

B. *Approximate Percentage of the Total Waste Incinerated that is Regulated Medical Waste.* Using the information from your operating log, calculate the percentage (by weight) of the total waste incinerated that is regulated medical waste. To do this, divide the amount of regulated medical waste incinerated by the total amount of waste incinerated. Multiply the result by 100. Enter the number in the space provided.

C. *Approximate Quantity of Regulated Medical Waste Received from Sources Outside this Facility.* Enter the total weight (in pounds) of regulated medical waste received from sources outside your facility during the six-month reporting period. An example of outside sources would include a facility that receives waste from a physician with an office several miles away.

Box 7. *Total Number of Incinerators at this Facility.* Enter the total number of incinerators that burn regulated medical waste at your facility. Only include incinerators that incinerate *regulated medical waste.*

Box 8. *Incinerator Design Information.* To complete Items A through D in this box, refer to design blue prints, manufacturer's information, or other sources.

A. *Age of Unit.* Enter the age of the incinerator unit in years.

B. *Type of Unit.* Mark an "X" in the box that describes this incinerator type.

- An "excess air" unit is usually a compact box-like structure with chambers and baffles, and it operates with high air flows to assure adequate combustion. It is usually loaded manually through a charging door.
- A "starved air" unit is usually cylindrical, but can be rectangular, and it typically has combustion air fed through the floor or on the sides. The waste is usually manually loaded, although larger units can be mechanically loaded.
- A "rotary kiln" unit is cylindrical and rotates about the lengthwise axis. If this incinerator is not described by any of the three groups listed, mark an "X" in the box labelled "other" and describe the unit in the space provided. If necessary, attach additional sheets.

C. *Number of Combustion Chambers.* Mark an "X" in the box that describes the number of combustion chambers in this incinerator.

D. *Design Charging Capacity.* Enter the maximum amount of waste that this incinerator is designed to burn, in pounds per hour. If you cannot locate any records, estimate the number of pounds per hour that this unit is designed to burn. [NOTE: When entering a quantitative response, such as, rates, weights or time, right justify the entry (e.g., | |2|0|0|0|0|)].

Box 9. *Certification.* After completing this form, the facility owner or an authorized representative must sign and date the certification and indicate his or her position.

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