MEDICAL WASTE MANAGEMENT PLAN

FACILITY INFORMATION:

Facility Name: ______________________________________________________________________________________________________________________________________
Address: ______________________________________________________________________________________________________________________________________________
City __________________________ State ___________ Zip Code ________________________________
Type Of Business __________________________________________________________
Phone Number: __________________ Email Address: ___________________________________________

Name Of Authorized Representative: __________________________________________________________________________________________________________________
Phone Number: __________________ Email Address: ___________________________________________

Name of Person Responsible For Implementation of the Medical Waste Management Plan:
________________________________________________________
Phone Number: __________________ Email Address: ___________________________________________

SECTION I. TYPES OF MEDICAL WASTE GENERATED AT THIS FACILITY (Check all that apply):

☐ Biohazardous waste, including:

  o Regulated/biomedical/clinical waste - material from the medical treatment of a human or animal suspected of being infected with a contagious pathogen; material from biomedical research; waste suspected of contamination with a highly communicable disease.
  o Laboratory waste - specimen or microbiological cultures; stocks of infectious agents; live and attenuated vaccines and culture mediums.
  o Blood or blood products - fluid human blood and blood products; containers or equipment containing human blood that is fluid.
  o Infectious waste - material contaminated with excretion, exudates or secretions from humans or animals isolated due to a highly communicable disease.
☐ **Sharps** - hypodermic needles, hypodermic needles with syringes, blades, needles with attached tubing, acupuncture needles, root canal files, broken glass items used in health care such as Pasteur pipettes and blood vials contaminated with biohazardous waste.

☐ **Pharmaceutical waste** - any prescription or over-the-counter medication which has no value (excludes material sent to a reverse distributor).

☐ **Pathology waste** - human body parts; human or animal surgery specimen that may be contaminated with infectious agents; surgery specimen or tissues that have been fixed in formaldehyde or another fixative.

☐ **Trace chemotherapeutic waste** - waste that is contaminated through contact with chemotherapeutic agents, including, but not limited to, gloves, disposable gowns, towels, and intravenous solution bags and attached tubing that are empty.

☐ **Other (specify)** - __________________________________________________________

SECTION II. TYPE OF FACILITY

1. This facility is classified as a:

- ☐ Small Quantity Generator (*less than 200 pounds per month*) with NO Onsite Treatment of Medical Waste
- ☐ Small Quantity Generator WITH Onsite Treatment
- ☐ Large Quantity Generator (*more than 200 pounds per month*) - less than 100 Licensed Beds with NO On-site Treatment
- ☐ Large Quantity Generator (*more than 200 pounds per month*) - 100-200 licensed beds with NO Onsite Treatment
- ☐ Large Quantity Generator (*more than 200 pounds per month*) – Over 200 licensed Beds with NO On-site Treatment
- ☐ Large Quantity Generator (*more than 200 pounds per month*) less than 100 Licensed Beds WITH Onsite Treatment
- ☐ Large Quantity Generator (*more than 200 pounds per month*) - 100-200 licensed beds WITH Onsite Treatment
- ☐ Large Quantity Generator (*more than 200 pounds per month*) – Over 200 licensed Beds WITH On-site Treatment
2. The *estimated quantity of medical waste* generated (including sharps waste) by this facility on a monthly basis is _________________ pounds.

3. Describe the method of handling: *segregation, containment or packaging, labeling, collection, and storage of each type* of medical waste within your facility.
   
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4. **MEDICAL WASTE STORAGE**
   
   Is this facility a Common Storage Facility that accumulates onsite, for collection by a registered hazardous waste hauler, medical waste from onsite Small Quantity Generators (SQG) who would otherwise operate independently?
   
   □ Yes    □ No

   If “Yes,” complete the following information for each SQG that uses this Common Storage Facility (attach additional pages if needed):

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5. Describe all disinfection procedures used in your facility for treatment or cleaning of reusable medical waste receptacles and medical waste spills.

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6. Describe the designated accumulation area(s) used for the storage of medical waste. (NOTE: Designated accumulation area is an area used for the storage of medical waste containers prior to transportation or treatment shall be secured so as to deny access to unauthorized persons. See Section 118310 for more detailed requirements.)

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7. Onsite Medical Waste Treatment (Check all that apply):

☐ This facility treats medical wastes onsite. ☐ Yes ☐ No
   If yes, what treatment method(s) are utilized?
   ☐ Incineration
   ☐ Steam sterilization (e.g. autoclave)
   ☐ Microwave Technology
   ☐ Other approved alternative treatment (Specify) ___________________________

☐ This facility uses a registered hazardous waste hauler to haul medical waste to an offsite treatment facility.

   Hauler Name: ________________________________________________

   Address: _______________________________________________________

   City/State/Zip: _________________________________________________

   Phone: __________________________

   Offsite Treatment Facility: ________________________________________
☐ Describe the training program for use of treatment equipment at this facility:
________________________________________________________________________
________________________________________________________________________
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☐ Describe the closure plan for the termination of treatment at this facility:
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SECTION III. EMERGENCY ACTION PLAN

Note: Large Quantity Generators are required to have an Emergency Action Plan. While not required for Small Quantity Generators (SQG), it is recommended that SQGs complete this section as a good management practice.

In the case of an emergency, such as equipment breakdown on the part of the registered hauler or natural disaster, medical waste will be (check one):

☐ Stored for up to seven days on the premises. Sufficient storage space is available in:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

☐ The following alternate registered medical waste hauler will be utilized:

Name: ________________________________________________________________

Address: ____________________________________________________________

City/State/Zip: ______________________________________________________
□ Describe in detail how this facility manages medical waste spills (e.g. gloves, mask, gown, disinfectant):

________________________________________________________________________
________________________________________________________________________
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□ Describe in detail how this facility handles, treats and disposes of liquid/semi-liquid laboratory waste:

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□ Describe employee training provided by employer.

Bloodborne Pathogen Training Provided? □ Yes □ No □ OTHER, describe below:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

SECTION IV. CATEGORIZING PHARMACEUTICALS

□ Describe the steps taken to categorize and properly dispose of the pharmaceutical wastes generated at this facility, specifically, how this facility will separate pharmaceuticals classified by the federal Drug Enforcement Agency (DEA) as “controlled substances” from the standard regulated medical waste stream:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
The following registered hazardous waste hauler will be utilized to haul pharmaceutical waste:

Name: __________________________________________________

Address: ______________________________________________

City/State/Zip: __________________________________________

I hereby certify that to the best of my knowledge and belief, the statements made herein are true and correct.

Signature ________________________________________________

Print name________________________________________ Date _____/_____/______