

INSTRUCTIONS FOR COMPLETION OF THE PLAN FOR HANDLING OF INFECTIOUS WASTES AT HEALTH CARE PRACTICES

The following information is provided to assist you in completing the infectious waste plan.

QUESTIONS 1- 3: Please verify that the mailing label is accurate and correct any information that has changed or is missing.

QUESTION 4: Kindly mark the appropriate box. Those requesting an exemptions should mark "other" and indicate the reason for the exemption.

QUESTIONS 5a-e: Only complete the sections that apply to your facility. Kindly mark "N/A" in the sections that are not applicable.

QUESTIONS 6a-f: The type of container, markings (e.g. "red plastic bag" marked infectious waste placed inside of a stationary container in each examining room is used for solid wastes. A rigid, tightly lidded, puncture resistant container is used for sharps.), storage area, etc. are to be described.

QUESTIONS 7a-g: These questions refer to on-site disposal (incinerator, autoclave, etc.) or transport and disposal off-site. Most of this information can be provided by attaching a copy of a manifest provided by the transporter.

QUESTION 8: Please sign and date in the appropriate location.

EXEMPTIONS: As a result of the nature of their employment, certain physicians may be exempt from completing the entire form and submitting the fee; however, question 5a must be completed stating the reason for the exemption [retired; no longer located in Philadelphia; administrator; employed in research by___ (company/university); intern/resident/fellow/faculty; psychiatrist not generating infectious waste; anesthesiologist or those physicians that do not generate **ANY** infectious waste outside of the hospital patient room/OR/DR/ER].

If you have any questions concerning completion of the form, please do not hesitate to contact the Environmental Engineering Section at (215) 685-7342.

**PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH
 PLAN FOR HANDLING OF INFECTIOUS WASTES AT HEALTH CARE PRACTICES
 (PLEASE TYPE OR PRINT NEATLY)**

1. NAME OF PRACTICE

2. ADDRESS OF PRACTICE

3A. NAME OF PERSON(S) OF AFFILIATION IN CHARGE OF PRACTICE

3B. NAME OF CONTACT PERSON(S)

C. TELEPHONE NUMBER

D. NUMBER OF PHYSICIANS IN PRACTICE

E. PHONE NUMBER DURING BUSINESS HOURS:

F. EMERGENCY CONTACT AFTER BUSINESS HOURS

4. TYPE OF FACILITY:

- MEDICAL
 DENTAL
 SURGICAL
 NURSING
 VETERINARIAN
 LABORATORY
 OTHER (*Please Describe*) _____

Fold

5. TYPE OF POTENTIAL INFECTIOUS WASTE:

A. DESCRIBE DISPOSABLE EQUIPMENT, INSTRUMENTS, UTENSILS OR OTHER OBJECTS THAT MAY COME IN CONTACT WITH INFECTIOUS MATERIALS:

B. DESCRIBE TYPE OF HUMAN SPECIMENS FROM PERSONS WITH POSSIBLE OR DIAGNOSED COMMUNICABLE DISEASE:

C. DESCRIBE TYPE OF ANIMAL SPECIMENS FROM ANIMALS WITH SUSPECTED OR DIAGNOSED COMMUNICABLE DISEASE:

D. DESCRIBE TYPE OF LABORATORY WASTES WHICH MAY HARBOR OR TRANSMIT INFECTIOUS MATERIALS (*check types*):

- MICROBIOLOGICAL
 BIOCHEMICAL
 HEMATOLOGICAL
 MICROSCOPICAL
 IMMUNOLOGICAL
 PARASITOLOGICAL

E. DESCRIBE OTHER WASTES WHICH MAY HARBOR OR TRANSMIT INFECTIOUS MATERIALS:

6. STORAGE SITE OF INFECTIOUS WASTES:

A. DESCRIBE CONTAINER(S) USED FOR STORAGE OF INFECTIOUS WASTES (INCLUDE TYPE OF MATERIAL CONTAINER IS MADE FROM, SIZE, LID):

B. DESCRIBE MARKINGS ON STORAGE CONTAINER:

C. IS THE STORAGE SITE FOR INFECTIOUS WASTES INTERIOR OR EXTERIOR? INTERIOR EXTERIOR BOTH

D. DESCRIBE MARKINGS ON INTERIOR OR EXTERIOR STORAGE SITE ENTRANCE:

E. DESCRIBE METHOD OF SECURING THE STORAGE SITE FOR INFECTIOUS WASTES:

F. DESCRIBE DURATION OF STORAGE BEFORE DISPOSAL (DESCRIBE DISPOSAL SCHEDULE):

7. DISPOSAL OF INFECTIOUS WASTES (Check One):

ON-SITE DISPOSAL OFF-SITE DISPOSAL OTHER _____

A. DESCRIBE METHOD OF DISPOSAL (WHETHER ON-SITE, OFF-SITE, OR OTHER):

B. DESCRIBE APPROXIMATELY HOW MUCH INFECTIOUS WASTE YOUR PRACTICE GENERATES ON A DAILY BASIS:

C. NAME OF TRANSPORTER OR PROCESSING/DISPOSAL COMPANY

D. PHONE NUMBER

E. ADDRESS OF TRANSPORTER OR PROCESSING/DISPOSAL COMPANY

F. IS THE DISPOSAL COMPANY USED BY YOUR PRACTICE LICENSED? IF SO, IN WHICH STATE IS IT LICENSED?

G. WHERE IS THE DISPOSED INFECTIOUS WASTE GENERATED BY YOUR PRACTICE TAKEN BY THE DISPOSAL COMPANY

8. APPLICANT CERTIFICATION

I hereby certify that the information contained herein is true and correct to the best of my knowledge and belief. I understand that if I knowingly make any false statement herein I am subject to legal action as a result of my false information and such other penalties as may be described by law.

Signature _____ Title _____ Date _____

WHEN COMPLETED MAIL THIS FORM AND FEE TO:

DEPARTMENT OF PUBLIC HEALTH
ENVIRONMENTAL HEALTH SERVICES
ENVIRONMENTAL ENGINEERING
7801 ESSINGTON AVENUE
PHILADELPHIA PA 19153

FOR OFFICE USE ONLY

PLAN RECEIVED: (DATE) _____
PLAN REVIEWED: (DATE) _____
APPROVAL: (DATE) _____
DISAPPROVAL: (DATE) _____

FEE INFORMATION

CLASSIFICATION _____
PAYMENT RECEIVED _____
PAYMENT AMOUNT \$ _____