STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
Department of Health
Office of Environmental Health Risk Assessment
3 Capitol Hill, 208 Cannon Building
Providence, RI 02908-5097
(401) 222-3424

INITIAL REGISTRATION OF REGULATED MEDICAL WASTE GENERATORS

PLEASE TYPE OR PRINT CLEARLY.

1. Facility Information:

A. Main Facility:
Facility Name_____

Address_____

City_____**State**_____**Zip Code**_____

Contact Person_____**Telephone**_____

B. Mailing address, if different from A above:
_____

City_____**State**_____**Zip Code**_____

C. Type of facility: please check appropriate box. If choosing the category "other", please specify.

[ ] 01 - hospital; [ ] 02 - laboratory; [ ] 03 - clinic/HMO; [ ] 04 - physician;
[ ] 05 - dentist; [ ] 06 - veterinarian; [ ] 07 - long-term care/nursing home;
[ ] 08 - blood bank; [ ] 09 - embalmer/funeral home; [ ] 10 - other_____

D. [ ] If this is an application for a group practice, please check this box and list all practitioners' names below:

_____ _____

_____ _____

E. [ ] If, according to the *Rules and Regulations Governing the Management and Handling of Medical Waste in Rhode Island*, you do not generate regulated medical waste, please check this box and go directly to Question 4 of the application (the signature block). Refer to the enclosed "Definitions" page for assistance.

(OVER)

2. Regulated Medical Waste Information:

A. Approximate total quantity of regulated medical waste generated at main facility, in pounds, in a 12 month reporting period: / / / / / / / /

B. Is regulated medical waste treated on-site?

[ ] yes - continue with 2B [ ] no - go to 2C
Method of treatment: [ ] autoclave; [ ] incineration;
[ ] other thermal treatment
(describe)_____
[ ] chemical treatment
(describe)_____
[ ] other treatment
(describe)_____

C. How is regulated medical waste transported off-site?
[ ] Registered RI Medical Waste Transporter
Transporter Name_____

Transporter Number_____

[ ] Generator/Employee Vehicle (may only be used if generating/shipping < 50 pounds of regulated medical waste per month)
Waste transported to:
Name of facility_____

Address_____

City_____State_____Zip Code_____

Telephone Number_____

3. Satellite Facility Information:

A. I/my organization generate(s) regulated medical waste at _____ satellite locations in RI. (If you generate RMW at facilities other than the facility indicated in Question 1A, please complete "Attachment A" for each satellite facility.)

B. The approximate total quantity of regulated medical waste generated, in pounds, in a 12 month reporting period, for all facilities (main and all satellites) in RI is: / / / / / / / /

4. Signature
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.

_____

Authorized Signature Title Date

A T T A C H M E N T A

Satellite Facilities

Attachment A must be completed if you generate regulated medical waste at more than one site in Rhode Island. Please refer to the enclosed page entitled, "Regulated Medical Waste (RMW) - Determining Your Generator Status" for instructions. If you generate RMW at more than one satellite site, you may photocopy this page and complete for each site.

A. Facility

Name_____

Address_____

City_____**State**_____**Zip Code**_____

Telephone_____

B. Regulated Medical Waste Information:

Approximate total quantity of regulated medical waste generated at this satellite facility, in pounds, in a 12 month reporting period: / / / / / / /

C. Is regulated medical waste treated on-site?

[ ] yes - continue with C
[ ] no - go to D

Method of treatment: [ ] autoclave; [ ] incineration;
[ ] other thermal treatment
(describe)_____
[ ] chemical treatment
(describe)_____
[ ] other treatment
(describe)_____

D. How is regulated medical waste transported off-site?

[ ] Registered RI Medical Waste Transporter
Transporter Name_____

Transporter Number_____

[ ] Generator/Employee Vehicle (may only be used if generating/shipping < 50 pounds of regulated medical waste per month)

Waste transported to:
Name of facility_____

Address_____

City_____**State**_____**Zip Code**_____

Telephone Number_____