Appendix III to Part 259—Transporter Report Form and Instructions

Page 1 of ___

TRANSPORTER REPORT

I. TRANSPORTER IDENTIFICATION INFORMATION

1. Reporting Period

☐ June 23, 1989 to December 19, 1989 ☐ June 18, 1990 to December 14, 1990

☐ December 20, 1989 to June 17, 1990 ☐ December 15, 1990 to June 12, 1991

2. Transporter Name and Mailing Address

Name

Address

City State Zip Code

3. EPA Medical Waste Identification Number

4. Certification for Intermediate Transporter

☐ Yes
☐ No

Signature

5. Contact Person

Name Title ( ) Telephone Number

6. 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.

Signature Title Date

II. DISPOSITION INFORMATION

7. Total Quantity of Regulated Medical Waste by Category and Destination

	Second Transporter or Transfer Facility	Intermediate Handler or Destination Facility
A. Untreated Waste	| | | | | | | | | | Pounds	| | | | | | | | | | Pounds
B. Treated Waste	| | | | | | | | | | Pounds	| | | | | | | | | | Pounds

Transporter Name or ID number ______________ page ___ of ___

III. GENERATOR IDENTIFICATION

8. Total Number of Generators From Whom Regulated Medical Waste was Accepted

(If your answer is "0", skip to section IV) |_|_|_|_|_|_|_|_|_|

9. Identity of Generators *Please Complete Sections A, B, and C for each Generator*

A. Name and Location of Generator ______________________ Generator Name ______________________ Street Address ______________________ City State Zip Code	**B. Type of Generator** |_|_| *Refer to instructions for code* **C. Quantity of Regulated Medical Waste Accepted From the Generator** Untreated |_|_|_|_|_|_|_|_|_| Pounds Treated |_|_|_|_|_|_|_|_|_| Pounds
A. Name and Location of Generator ______________________ Generator Name ______________________ Street Address ______________________ City State Zip Code	**B. Type of Generator** |_|_| *Refer to instructions for code* **C. Quantity of Regulated Medical Waste Accepted From the Generator** Untreated |_|_|_|_|_|_|_|_|_| Pounds Treated |_|_|_|_|_|_|_|_|_| Pounds
A. Name and Location of Generator ______________________ Generator Name ______________________ Street Address ______________________ City State Zip Code	**B. Type of Generator** |_|_| *Refer to instructions for code* **C. Quantity of Regulated Medical Waste Accepted From the Generator** Untreated |_|_|_|_|_|_|_|_|_| Pounds Treated |_|_|_|_|_|_|_|_|_| Pounds
A. Name and Location of Generator ______________________ Generator Name ______________________ Street Address ______________________ City State Zip Code	**B. Type of Generator** |_|_| *Refer to instructions for code* **C. Quantity of Regulated Medical Waste Accepted From the Generator** Untreated |_|_|_|_|_|_|_|_|_| Pounds Treated |_|_|_|_|_|_|_|_|_| Pounds

Transporter Name or ID Number ________________ page ___ of ___

IV. INTERMEDIATE HANDLER OR DESTINATION FACILITY IDENTIFICATION

10. Total Number of Intermediate Handlers or Destination Facilities to which Regulated Medical Waste was Delivered |_|_|_|_|_|_|_|_| *(If your answer is "0", do not continue with this section)*

11. Identity of Intermediate Handlers or Destination Facilities

Please Complete Sections A and B for each Facility

A. Name and Location of Facility

Facility Name ________________

Street Address ________________

City ________ State ________ Zip Code ________

B. Type of Facility |_|_|

Refer to instructions for code

C. Quantity of Regulated Medical Waste Delivered to the Facility

Untreated |_|_|_|_|_|_|_|_|_| Pounds

Treated |_|_|_|_|_|_|_|_|_| Pounds

A. Name and Location of Facility

Facility Name ________________

Street Address ________________

City ________ State ________ Zip Code ________

B. Type of Facility |_|_|

Refer to instructions for code

C. Quantity of Regulated Medical Waste Delivered to the Facility

Untreated |_|_|_|_|_|_|_|_|_| Pounds

Treated |_|_|_|_|_|_|_|_|_| Pounds

A. Name and Location of Facility

Facility Name ________________

Street Address ________________

City ________ State ________ Zip Code ________

B. Type of Facility |_|_|

Refer to instructions for code

C. Quantity of Regulated Medical Waste Delivered to the Facility

Untreated |_|_|_|_|_|_|_|_|_| Pounds

Treated |_|_|_|_|_|_|_|_|_| Pounds

A. Name and Location of Facility

Facility Name ________________

Street Address ________________

City ________ State ________ Zip Code ________

B. Type of Facility |_|_|

Refer to instructions for code

C. Quantity of Regulated Medical Waste Delivered to the Facility

Untreated |_|_|_|_|_|_|_|_|_| Pounds

Treated |_|_|_|_|_|_|_|_|_| Pounds

BILLING CODE 6560-50-C

General Information

Authority

This information is required by EPA under the authorities of Section 11003 and 11004 of the Resource Conservation and Recovery Act. EPA expects that you will provide this information based on the records you are required to keep as a medical waste transporter.

Who Must Complete This Report?

This report must be completed by transporters of regulated medical waste who accept and transport regulated medical waste generated in a Covered State, and who are required to obtain an EPA Medical Waste Identification Number under § 259.72 of this Part.

What Type of Information Is Required By This Report?

The Transporter Report Form collects information on the source and disposition of regulated medical waste handled by a transporter. The form is divided into four sections:

I. Transporter Identification Information
II. Disposition Information
III. Generator Identification
IV. Intermediate Handlers and Destination Facility Identification

How to Complete These Forms?

A separate copy of this form must be completed for each Covered State in which the regulated medical waste which you have transported, during the reporting period was generated.

[Note: If you did not transport regulated medical waste generated in a Covered State during a reporting period, you do not have to submit a Transporter Report Form for that Covered State for that reporting period]. The examples described below illustrate who (i.e., those transporters) must report, and for which Covered States:

Example 1: Company X accepts waste generated in New York. (In this scenario New York is assumed to be a Covered State and New Hampshire, a non-Covered State.)

Company X accepts regulated medical waste from six generators located in New York and transports the waste for disposal to two facilities in New Hampshire. (Because New York is a Covered State under the demonstration program, Company X must notify EPA that it accepts and transports regulated medical waste generated in a Covered State. EPA will issue an EPA Medical Waste Identification Number to Company X for the State of New York.)

In this case, Transporter X only accepts and transports regulated medical waste from one Covered State and, thus, will only have to complete one report, for the State of New York.

Example 2: Company Y accepts regulated medical waste generated in New Jersey and New York. (In this scenario both New Jersey and New York are assumed to be Covered States, and New Hampshire a non-Covered State.)

Company Y accepts regulated medical waste from four generators in New York and from five generators in New Jersey. Company Y delivers the waste accepted from these generators to a destination facility in New Hampshire. (Company Y notifies EPA that it accepts and transports regulated medical waste that is generated in two Covered States. EPA issues two EPA Medical Waste Identification Numbers to Company Y, the first identification number is for the transport of regulated medical waste generated in New York and the second number is for the transport of regulated medical waste generated in New Jersey.)

Because Company Y has accepted waste generated in two Covered States, the company will be required to complete and submit two Transporter Report Forms, one for the waste from the four generators in New York and a separate Transporter Report Form for the five generators in New Jersey.

Example 3: Three transporter companies, Company X, Company B, and Company Y, transport regulated medical waste generated in New York. (Again, in this scenario New York is assumed to be a Covered State and New Hampshire, a non-Covered State.)

Company X accepts regulated medical waste from six generators located in New York and transports the waste to Company B who is an intermediate transporter located in New Hampshire. Company B accepts the waste from Company X and transports the waste to Company Y, also located in New Hampshire, who then delivers the waste to a destination facility in New Hampshire. (Because New York is a Covered State, all three companies (X, B, and Y) must notify EPA that they accept and transport regulated medical waste generated in a Covered State.)

Each transporter company must also complete a separate Transporter Report Form. In completing the form, Company X must supply information on each New York generator from whom it accepts regulated medical waste, and on the quantities it accepted. Company Y must supply information on the disposal facility to which it delivers the regulated medical waste and the quantities it delivered. Company B must only supply information to verify it is an "intermediate transporter" as it neither accepted waste directly from a generator nor delivered waste to an intermediate handler or destination facility.

When to Complete the Report?

Complete each Transporter Report using the information that can be obtained from the tracking forms and transporter logs. Use only those tracking forms and logs that have certification receipt dates in Box 16 of the tracking form, that fall within the reporting periods identified below. Submit the report no later than 45 days following each reporting period. The schedule of submission dates are as follows:

Reporting period	Submission date
June 23, 1989 to December 19, 1989.	February 2, 1990.
December 20, 1989 to June 17, 1990.	August 1, 1990.
June 18, 1990 to December 14, 1990.	January 28, 1991.
December 15, 1990 to June 12, 1991.	July 27, 1991.

Where to Send This Report?

Copies of each report must be submitted as follows:

(1) One copy must be submitted to: Chief, Waste Characterization Branch (OS-332), Office of Solid Waste, U.S. Environmental Protection Agency, 401 M Street SW., Washington, DC 24060.

(2) A second copy must be submitted to the Director of the waste management agency in the State for which the transporter has compiled the report.

Instructions for Completing the Form

The item by item instructions that follow explain for each type of transporter which Sections I–IV they must complete.

[Note: If your company accepts and transports regulated medical waste from generators located in a Covered State and you have not been issued an EPA Medical Waste Identification Number, you still must complete this form for each Covered State's waste which you have transported during the reporting period.

After completing the entire form, number each page appropriately in the space provided (e.g., page 14 of 15).]

Section I. Transporter Identification Information

Boxes 1 through 6 requires the submittal of information on the reporting period and your transporter operations. Begin with Box 1 and continue sequentially with each Box.

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

Box 2. *Transporter Name and Mailing Address.* Enter the name and the mailing address of the transporter who is completing this report.

Box 3. *EPA Medical Waste Identification Number.* Enter the 12 digit identification number assigned to your company's transporter operations in the Covered State for which you are completing this form. If you do not have an identification number, enter the name of the Covered State for which you are completing this form.

Box 4. *Certification for Intermediate Transporter.* Transporters who (1) solely accept regulated medical waste from transporters who have, themselves, transported the waste, and (2) deliver such waste only to another transporter for further movement, are considered "intermediate transporters" and need only complete Boxes 1 through 6. If you are an intermediate transporter, mark an "X" in the box corresponding to "YES" and enter your signature after the box. If you are not an intermediate transporter, mark an "X" in the box corresponding to "NO". In both cases, continue on to Box 5.

Box 5. *Contact Person.* Enter the name, title, and telephone number of the person who is most knowledgeable about your transportation operations, or the person who

is responsible for the information in this report.

Box 6. *Certification.* After completing this form, the company owner or an authorized representative must sign and date the certification and indicate his or her title or position. If your organization has no legal owner (e.g., a local government entity), the individual within your organization who is responsible for the information in this report must sign and date the certification and indicate his or her position.

If you were an intermediate transporter during the reporting period marked in Box 1, you do not need to complete the remaining sections of this report. If, however, you accepted regulated medical waste directly from a generator located in a Covered State, or you delivered such waste to an intermediate handler or destination facility during the reporting period marked in Box 1, continue with Sections II, III and IV and follow the instructions.

Section II. Disposition Information

This section requires submittal of information on the quantities of regulated medical waste you transported during the reporting period marked in Box 1.

Box 7. *Total Quantity of Regulated Medical Waste by Category and Destination.* This box requests information on the total quantity of (A) untreated and (B) treated regulated medical waste you accepted for transport during the reporting period. The total quantity of waste should only include the regulated medical waste you transported that was generated in the Covered State for which you are completing this form. For each category of waste, enter the quantity of waste (in pounds) that was delivered (1) to a second transporter or transfer facility and (2) to an intermediate handler or destination facility. If either category of waste was not delivered to a facility, enter "0" for that category and facility combination. If you did not deliver waste to one of the types of facilities, enter "0" for that facility type. Right justify each entry (e.g., | |2 |0 |0 |0 |).

Section III. Generator Identification

This section requires the submittal of information regarding the generators from whom you accepted regulated medical waste during the reporting period marked in Box 1.

Box 8. *Total Number of Generators from whom Regulated Medical Waste was Accepted.* Enter the total number of generators from whom you accepted regulated medical waste for transport during the reporting period. Include only those generators located in the Covered State for which you are completing this form. If your company did not pick up any regulated medical waste directly from a generator, enter "0" in the box and skip to Section IV. Right justify each entry (e.g., | | |1 |4 |3 |).

Box 9. *Identity of Generators.* Complete Boxes 9A through 9C *on each individual generator* in the Covered State from whom you accepted regulated medical waste during the reporting period. This form provides space for identification of four generators. If you accepted waste from more than four generators, copy this page as needed and provide the information on each generator. The number of generators entered in Box 8 must equal the total number of all generators identified in Box 9.

9A. *Name and Location of Generator.* Enter the name and the address representing the physical location of the generator (i.e., the location at which the waste is picked up).

9B. *Type of Generator.* Enter one of the following codes that best classifies the type of generator. Use your best judgment as to the generator's type.

Code	Generator type
01	Hospital—includes waste generated in all laboratories and departments.
02	Laboratory—including clinical and research laboratories generating regulated medical waste.
03	Clinic—includes group-practice facilities that provide ambulatory care of one or more specialties such as hemodialysis, prenatal, or post partum care, surgical centers, family practice centers, etc. Also includes outpatient drug treatment facilities, and nonresidential medical day care facilities.
04	Physician—includes single and multiple private-practice physician offices.
05	Dentist—includes single and multiple private-practice dentist offices.
06	Veterinarian—includes single and multiple private-practice veterinarian offices.
07	Long Term or Residential Health Care Facility—includes facilities providing skilled or non-skilled care such as nursing homes and residential drug treatment centers.
08	Blood Banks—includes freestanding blood banks (not at a hospital) and their mobile off-site activities.
09	Other—includes any other facility generating regulated medical waste such as ambulance services, infirmaries, etc. If you enter this code, specify the type of generator in the space after the code.

9C. *Quantity of Regulated Medical Waste Accepted from the Generator.* For each category (untreated and treated), enter the amount of waste (in pounds) that you accepted from the generator during the reporting period. If you did not accept waste in one of the categories, enter "0." Right justify each entry (e.g., | | |2|0|0|0| pounds).

Section IV. Intermediate Handlers or Destination Facilities Identifiction

Boxes 10 and 11 requires the submittal of information regarding the intermediate handlers and destination facilities to which you delivered regulated medical waste during the reporting period marked in Box I.

Box 10. *Total Number of Intermediate Handlers and Destination Facilities to which Regulated Medical Waste was Delivered.* Enter the total number of intermediate handlers and destination facilities to which you delivered regulated medical waste during the reporting period. This box should include *all* facilities (in both Covered and non-Covered States) that accepted the regulated medical waste listed in Box 7. If you did not deliver any regulated medical waste to an intermediate handler or destination facility during the reporting period enter "0" in the Box and do not complete the remainder of this section. Right justify your entry (e.g., | | |2|9|).

Box 11. *Identity of Intermediate Handlers and Destination Facilities.* Complete Boxes 11A through 11C *identifying each individual intermediate handler and destination facility* to which you delivered regulated medical waste generated in the Covered State for which this form is completed. This form provides spaces for identification of four facilities. If you delivered waste to more than four facilities, copy this page as needed and provide the requested information for each facility. The number of facilities entered in Box 10 must equal the number of facilities identified in Box 11.

11A. *Name and Location of Facility.* Enter the name and the address representing the physical location of the facility.

11B. *Type of Facility.* Enter one of the following codes that best classifies the type of facility:

Code	Facility type
1	Landfill.
2	Incinerator.
3	Treatment (other than incinerator).
4	Destruction Facility (other than incinerator).
5	Treatment and Destruction Facility (other than incinerator).

11C. *Quantity of Regulated Medical Waste Delivered to the Facility.* For each category (untreated and treated) enter the quantity of waste (in pounds) that you accepted for transport to the intermediate handler or destination facility during the reporting period. If you did not deliver waste in one of the categories enter "0" for that category. Right justify each entry (e.g., |0|0|2|0|0|0| pounds).

BILLING CODE 6560-50-M

Appendix IV to 40 CFR Part 259 Recommended Medical Waste Transporter Notification Form and Instructions

United States
Environmental Protection
Agency

Medical WasteTransporter Notification Form

FOR OFFICIAL EPA USE ONLY

Identification No.: _ _ _ _ _ _ _ _ _ _ _ _

Date Received: ___ / ___ / ___

Receiving Official: ____________

(Please Type or Print Clearly)

1. Covered State for which you are notifying ____________

2. Transporter Name and Mailing Address

Name ____________

Address ____________

City ____ State ____ Zip Code ____

Contact ____ Area Code/Telephone Number ____

3. EPA Hazardous Waste ID Number

_ _ _ _ _ _ _ _ _ _ _ _

(The ID number entered should be for the facility identified in Box 2)

4. Transporter's Facility Location(s) *(use additional sheets if necessary)*

Address ____________

City ____ State ____ Zip Code ____

Area Code/ Telephone Number ____________

Any current State Identification number(s) (permit or license) required to handle medical or infectious waste ____________

Address ____________

City ____ State ____ Zip Code ____

Area Code/ Telephone Number ____________

Any current State Identification number(s) (permit or license) required to handle medical or infectious waste ____________

Address ____________

City ____ State ____ Zip Code ____

Area Code/ Telephone Number ____________

Any current State Identification number(s) (permit or license) required to handle medical or infectious waste ____________

Address ____________

City ____ State ____ Zip Code ____

Area Code/ Telephone Number ____________

Any current State Identification number(s) (permit or license) required to handle medical or infectious waste ____________

Address ____________

City ____ State ____ Zip Code ____

Area Code/ Telephone Number ____________

Any current State Identification number(s) (permit or license) required to handle medical or infectious waste ____________

Address ____________

City ____ State ____ Zip Code ____

Area Code/ Telephone Number ____________

Any current State Identification number(s) (permit or license) required to handle medical or infectious waste ____________

5. Certification

I certify, under penalty of criminal or civil prosecution for making or submission of false statements, representations or omissions, that I have read, understand, and will comply with the regulations at 40 CFR Part 259, issued under authority of Subtitle J of the Resource Conservation and Recovery Act.

Signature ____________ Title ____________ Date ____________

BILLING CODE 6560-50-C

Instructions for Completing the Medical Waste Transporter Notification Form

General Information

Authority

This information is required by the EPA under authority of Section 11003 and 11004 of the Resource Conservation and Recovery Act.

Who Must Notify: Transporters who transport regulated ...edical waste that is generated in a Covered State must notify the U.S. Environmental Protection Agency for each Covered State's regulated medical waste they intend to transport. This requirement extends to transporters who do not actually transport the waste within that Covered State's boundaries but who transport the waste, generated in the Covered State, outside that Covered State's boundaries.

Transporters planning such activity may either complete a Notification Form or submit a letter containing the information required in 40 CFR 259.72(b). EPA will then issue a Medical Waste Identification Number unique to that transporter for each Covered State for which they are notifying. That number will be used to identify regulated medical waste transporters and can be used by generators to verify that the transporter has notified EPA of his intent to transport waste from their Covered State.

When to Notify: Notification must be submitted for a Covered State before the transporter may accept regulated medical waste generated in that Covered State. Transporters may, however, accept such waste once they have submitted their notification, but before receiving their identification number. Upon receipt of that number, the transporter must enter it in Box 5 of the Medical Waste Tracking Form, when that form is required. Additionally, the transporter must enter that number in Box 17 of the Tracking Form when acting as a secondary transporter, and in Box 1 when initiating a tracking form for load consolidation purposes.

Where to Send Notification: Two copies of the completed Notification Form, for each Covered State, must be sent to: Chief, Waste Characterization Branch, Environmental Protection Agency (OS–332) 401 M Street, SW., Washington, D.C. 20460.

One copy must also be sent to the Director of the waste management agency in the State for which the transporter is notifying.

Notification Form Instructions

Note: All information must be typed or printed clearly.

Box 1. *Covered State for which you are notifying.* Enter the name of the Covered State of origin of the regulated medical waste(s) you intend to collect and/or transport. Enter only one State in this space; if you intend to transport waste from more than one Covered State you must submit a separate Notification Form for each of those States.

Box 2. *Transporter Name and Mailing Address.* Enter your organization's name, mailing address, the name of a contact person at that location who is knowledgeable about your operations, and include that person's telephone number.

Box 3. *EPA Hazardous Waste Identification Numbers.* If the facility identified in Box 2 has an EPA Hazardous Waste Identification Number, enter the EPA-assigned 12-character hazardous waste identification number for the facility.

Box 4. *Transporter's Facility Location(s).* Enter the address, facility telephone number and any current State medical or infectious waste permit or license numbers for each transportation or transfer facility located within the Covered State identified in Box 1.

If there are more than four such facilities in that Covered State you will need to use an additional sheet(s) to provide the required facility information; attach the additional sheets to the first.

Box 5. *Certification.* The Certification Statement must be read and hand signed by a corporate officer or the owner/operator of the transporter company.

[FR Doc. 89–6304 Filed 3–23–89; 8:45 am]

BILLING CODE 6560–50–M

U.S. GOVERNMENT PRINTING OFFICE: 1989 O—942-208