COMMUNITY AND ECONOMIC DEVELOPMENT DEPARTMENT
Division of Environmental Health

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Director

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Equal Opportunity Employer

MEDICAL WASTE TRACKING DOCUMENT

GENERATOR INFORMATION

Facility Name:

Address:

Phone Number:

Date of Medical Waste Shipment:

TRANSPORTER INFORMATION (to be completed by the transporter)

Transporter Name:

Address:

Phone number:

Registration Number (if applicable):

MEDICAL WASTE TRANSPORTED

Type(s) of Waste:	**Number of Containers:**

RECEIVING FACILITY INFORMATION (to be completed by the receiving facility)

Facility Name:

Address:

Phone Number:

Permit Number:

Authorized Representative Name:

Authorized Representative Signature:

Date Medical Waste Shipment was Received:

TREATMENT FACILITY INFORMATION (to be completed by the treatment facility)

Facility Name:

Address:

Phone Number:

Date of Medical Waste Treatment: