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|---------------|-------|
| Date Received | _____ |
| Permit No. | _____ |
| Date Issued | _____ |

Department of Health

Application for Biomedical Waste Sharps Collection Program Permit

Permits expire on September 30 of each year. Permits must be renewed annually. Submit the following information on this form to your local Department of Health Biomedical Waste Coordinator.

1. Program Status: _____ **New** _____ **Renewal**
2. Facility Name: _____
3. Facility Address: _____

Street
City
State
Zip Code
4. Contact Person: _____ Telephone: (____) _____
5. Mailing Address of Contact: _____

Street
City
State
Zip Code
6. Business Phone: (____) _____
7. 24-Hour Emergency Phone: (____) _____
8. List all collection facilities intended for coverage under this permit, including the street address and city, state, zip code and phone number (attach additional sheets if necessary): _____

9. Describe how the program will function or operate (attach additional sheets if necessary): _____

10. Describe where biomedical waste will be stored and treated: _____

11. Beginning date of program: _____

Certification:

To the best of my knowledge and belief, I certify that I understand and will comply with the applicable requirements of Chapter 64E-16, F.A.C., and that the information provided in this notification is true and accurate.

 Signature of Authorized Representative Name of Authorized Representative (print or type) Date