Department of Health
Application for Biomedical Waste Storage Permit

Pursuant to Chapter 64E-16, Florida Administrative Code (F.A.C.), a facility which stores biomedical waste must obtain an annual permit from the department. The initial permit fee is $85.00. Permits expire September 30 of each year. The permit fee for renewal applications received by October 1 is $85.00. The permit fee for renewal applications received after October 1 is $105.00. State-owned and operated biomedical waste facilities are exempt from the permit fee. Submit the following information on this form to your local Department of Health Biomedical Waste Coordinator.

1. Application For (Choose One):  _____ New  _____ Renewal
   (Applicant must be a legal entity, i.e.: individual, partnership, corporation, association, or public body)

2. Facility Name: ____________________________

3. Facility Address:  
   Street: ____________________________  City: ____________________________  State: ____________________________  Zip Code: ____________________________

4. Contact Person: ____________________________  Telephone: (__________)

5. Name of Facility Owner: ____________________________

6. Mailing Address of Facility Owner:  
   Street: ____________________________  City: ____________________________  State: ____________________________  Zip Code: ____________________________

7. Business Phone: (__________)

8. 24-Hour Emergency Phone: (__________)

9. Name of Property Owner: ____________________________

10. Mailing Address of Property Owner:  
    Street: ____________________________  City: ____________________________  State: ____________________________  Zip Code: ____________________________

11. Describe the general layout and operation of the facility or equipment (attach additional sheets, if necessary):
    __________________________________________________________
    __________________________________________________________
    __________________________________________________________

12. Date of beginning operation: ____________________________

13. List where the biomedical waste will be treated or taken for further storage:
    __________________________________________________________
    __________________________________________________________
    __________________________________________________________
    __________________________________________________________

I certify that, to the best of my knowledge, the information provided in this application is true and accurate.

____________________________________  ________________________________  __________
Signature of Authorized Representative  Name of Authorized Representative (print or type)  Date