Community and Economic Development
Environmental Health Division

Dexter Marr
Deputy Director

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REGISTRATION/PERMIT APPLICATION FOR MEDICAL WASTE GENERATION AND TREATMENT

GENERATOR NAME: ____

BUSINESS ADDRESS:

Street: ____

City: ______________________ State: __________ Zip: ______________

Phone Number: ____________________________

AUTHORIZED REPRESENTATIVE:
____

TITLE: ____

EMERGENCY TELEPHONE NUMBER: ______________________________

APPLICATION FOR:

- ☐ Small quantity generator only. *Less than 200 pounds of medical waste*
- ☐ Small quantity generator with onsite treatment. *Less than 200 pounds of medical waste*
- ☐ Large quantity generator only. *More than 200 pounds of medical waste*
- ☐ Large quantity generator with onsite treatment. *More than 200 pounds of medical waste*
- ☐ Common storage facility permit.

ALL APPLICANTS PLEASE COMPLETE THE APPROPRIATE SUPPLEMENTARY FORMS.

I declare under penalty of law that to the best of my knowledge and belief the statements made herein are correct and true. I hereby consent to all necessary inspections made pursuant to the California Medical Waste Management Act and incidental to the issuance of this Registration/Permit and the operation of this business.

______________________	______________________	______________________
SIGNATURE	PRINTED NAME	DATE

OWNER/OPERATOR INFORMATION (Responsible Party For Billing)

Owner/Operator Name: ____

Home Address: __________________________ City: _________________ ST: ____ Zip: _______

Mailing Address: _________________________ City: _________________ ST: ____ Zip: _______

Home Phone: ( ) ______________________ Work Phone: ( ) _______________________

FACILITY INFORMATION

APN: _______-_______-_______

Business Name:____

Business Address: ____________________________ City: ____________ ST:______Zip: _______

Mailing Address: _____________________________ City: ____________ ST: ______ Zip: _______

Business Phone: ( ) ________________________ E Mail: _____________________________

Manager or Person in Charge: ________________________ Contact Phone: ( ) _____________

MAIL INVOICES TO: OWNER/OPERATOR______ FACILITY______

BILLING AND COMPLIANCE ACKNOWLEDGEMENT:

I, the undersigned owner, operator or agent, acknowledge that all fees associated with this facility or activity will be billed to the party identified as the OWNER/OPERATOR on this form.

I also certify that all operations will be performed in accordance with all applicable Madera County Ordinance Codes and/or Standards and State and/or Federal Laws.

I understand that the annual Medical Waste Generator Permit is non-transferable to a different owner/operator and upon change of ownership, or the closure of a business, I will notify this Department in writing within 10 business days before the change occurs.

APPLICANT'S SIGNATURE: ___________________________________ DATE: _________________

Failure to pay annual Medical Waste Generator Permit fees constitutes operating without a valid permit and the owner/ operator is subject to facility closure and/or penalties.

ENVIRONMENTAL HEALTH USE ONLY

COMMENTS: ____

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RECEIVED BY: ____ DATE: ________________________________