



<b>DH use only:</b> Check No. _____	Check Amount _____
Date Received _____	Receipt No. _____
Permit No. _____	Date Issued _____

# 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 \$55.00. When the facility shall be in operation six (6) months or less before the annual renewal date, the initial fee shall be prorated on a quarterly basis. Permits expire September 30 of each year. The permit fee for renewal applications received by October 1 is \$55.00. The permit fee for renewal applications received after October 1 is \$75.00. 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

