



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