Med Waste MANAGEMENT
Safety, Reliability & Compliance

MANIFEST #

CODE AREA

GENERATOR

COMPANY NAME | TELEPHONE NUMBER

ADDRESS

I certify that the information provided is true and correct, and that the generated materials are properly classified, described, packaged, labeled/placarded; and are in proper condition for transportation according to the applicable regulations of the U.S. Department of Transportation.

NAME OF COMPANY REPRESENTATIVE (Print) | SIGNATURE OF REPRESENTATIVE | DATE

PRIMARY TRANSPORTER

NAME(S) OF PERSONS COLLECTING, TRANSPORTING OR UNLOADING WASTE | INITIALS | REGISTRATION NUMBER

COMPANY NAME | TELEPHONE NUMBER

ADDRESS | DATE MEDICAL WASTE COLLECTED

# cont.	wt. #	# cont.	wt. #	# cont.	wt. #	# cont.	wt. #	# cont.	wt. #

I certify that the information provided above is true and correct and that only untreated medical wastes are contained in this load. I am aware that falsification of this manifest may result in forfeiture of my transporter's registration and/or the privilege of utilizing State-authorized facilities.

NAME OF COMPANY REPRESENTATIVE (Print) | SIGNATURE OF REPRESENTATIVE | DATE

TRANSFER STATION: NAME | REGISTRATION NUMBER

TRANSFER STATION / TRANSPORTER 2

NAME(S) OF PERSONS COLLECTING, TRANSPORTING OR UNLOADING WASTE | INITIALS | REGISTRATION NUMBER

COMPANY NAME | TELEPHONE NUMBER

ADDRESS | DATE MEDICAL WASTE COLLECTED

# cont.	wt. #	# cont.	wt. #	# cont.	wt. #	# cont.	wt. #	# cont.	wt. #

I certify that the information provided above is true and correct and that only untreated medical wastes are contained in this load. I am aware that falsification of this manifest may result in forfeiture of my transporter's registration and/or the privilege of utilizing State-authorized facilities.

NAME OF COMPANY REPRESENTATIVE (Print) | SIGNATURE OF REPRESENTATIVE | DATE

TREATMENT FACILITY

COMPANY NAME | TELEPHONE NUMBER

ADDRESS

PERMIT NUMBER | DATE WASTE WAS DEPOSITED/UNLOADED | TOTAL WEIGHT DEPOSITED/UNLOADED

DISCREPANCY INDICATION SPACE

I certify that I have been authorized to accept untreated medical wastes and that I have received the above indicated wastes in accordance with the requirements outlined in that authorization.

NAME OF COMPANY REPRESENTATIVE (Print) | SIGNATURE OF REPRESENTATIVE | DATE

In case of emergency, call (_____)_____ (24-hr company or other emergency response group telephone)