

BIOMEDICAL WASTE GENERATOR REGISTRATION FORM
(Pursuant to 38 M.R.S.A. Section 1319(O) and 06-096 CMR 900)

Is this an application for a new biomedical waste generator registration number? Yes No
If yes, please remit the \$50 initial registration fee with this form. See Section #7 below.
If no, your existing biomedical generator registration number must be included in Section #2A below.

Section 1: Registrant Information (This is the entity that owns the facility where biomedical waste is generated.)

- A. Full Legal Name:
- B. Mailing Address:
City: _____ State: _____ Zip Code (+4): _____
- C. Telephone #: " " " " Web site URL: _____
- D. Employer Identification Number (EIN): _____

Section 2: Generator Information (This is the specific location where biomedical waste is generated.)

- A. Biomedical Waste Generator Registration Number (if previously assigned): _____
- B. Facility Name: _____
- C. Street Address:
City: _____ State: _____ Zip Code (+4): _____
- D. Mailing Address: (If different from Street Address)
City: _____ State: _____ Zip Code (+4): _____
- E. Telephone #: " " " " _____
- F. **If you no longer generate biomedical waste, please check here , provide date of closure, sign and return this form. This facility closed on this date,** _____

Section 3: Primary Type of Facility (Please check only one)

- | | | |
|--|---|---|
| <input type="checkbox"/> A. Blood Bank | <input type="checkbox"/> I. Dialysis Center | <input type="checkbox"/> Q. Nursing Home |
| <input type="checkbox"/> B. Chiropractor | <input type="checkbox"/> J. Doctor's Office | <input type="checkbox"/> R. Outpatient Surgical Ctr |
| <input type="checkbox"/> C. Clinic | <input type="checkbox"/> K. Emergency Medical Service | <input type="checkbox"/> S. Research Facility |
| <input type="checkbox"/> D. Clinical Lab | <input type="checkbox"/> L. Employee Health Clinic | <input type="checkbox"/> T. Residential Care Facility |
| <input type="checkbox"/> E. College/University | <input type="checkbox"/> M. Funeral Home | <input type="checkbox"/> U. Veterinary |
| <input type="checkbox"/> F. Commercial | <input type="checkbox"/> N. Hospital | <input type="checkbox"/> V. Other _____ |
| <input type="checkbox"/> G. Corrections Facility | <input type="checkbox"/> O. Manufacture/Industry | |
| <input type="checkbox"/> H. Dentist | <input type="checkbox"/> P. Municipality/School | |

Section 8: Certification

By signing this form, I certify that all information is accurate and complete, and that I will comply with all applicable laws and regulations concerning the management of biomedical waste. I am aware that there are substantial penalties for falsification or misrepresentation of information submitted to the Department of Environmental Protection as part of this registration application.

Date:

Owner or Authorized Employee (Please type or print)

Title

Signature: _____

Thank you.