Medical Waste Management Program

Medical Waste Transporter Annual Verification

Company

Company Name:			
Number of Vehicles used to transport waste:			
DTSC Transporter Registration Number:		Expiration Date:	
Facility Contact Person:		Telephone Number:	
Email:			
Street Address:			
City:	County:	State:	Zip Code:
Mailing Address:			
City:		State:	Zip Code:
Web Address:			

Type of Waste Collected and Estimation of Pounds

Sharps	Biohazardous Red Bag	Pharmaceutical	Pathology	Trace Chemotherapy	Trauma Scene Waste

Medical Waste Facility

TS/TS-OST ID	Permitted Facility Utilized or Mail-back Information	Facility Address (City/State/ZIP code)	Off-Site Treatment	Transfer Station
			☐Yes	☐Yes
			☐Yes	☐Yes

Certification

I certify under penalty of perjury that the information contained in this application is true and accurate to the best of my knowledge and belief.

Authorized Representative:	Title:
Signature:	Date:

Required Documents:

- ✓ A copy of the service agreement with the transfer station /off-site treatment facility.
- ✓ A sample medical waste tracking document.
- ✓ A copy of the DTSC Hazardous Waste Transporter Registration certificate.

Mail the application to:
California Department of Public Health
Medical Waste Management Program
MS 7405
P.O. Box 997377
Sacramento, CA 95899-7377

Or courier to:
California Department of Public Health
Medical Waste Management Program
MS 7405
1616 Capitol Ave, 2nd Floor
Sacramento, CA 95814