



**REGISTRATION/PERMIT APPLICATION FOR
MEDICAL WASTE GENERATION AND TREATMENT**

GENERATOR'S NAME: _____

BUSINESS ADDRESS:

Street _____

City _____ State _____ Zip _____

Phone Number () _____ - _____

AUTHORIZED REPRESENTATIVE: _____

TITLE: _____

EMERGENCY TELEPHONE NUMBER: () _____ - _____

APPLICATION FOR:

- Small quantity generator with onsite treatment.
- Large quantity generator only.
- Large quantity generator with onsite treatment.
- Home-generated sharps and/or pharmaceutical collection site.

**ALL APPLICANTS PLEASE COMPLETE THE APPROPRIATE
SUPPLEMENTARY FORMS.**

I declare under penalty of law that to the best of my knowledge and belief the statements made herein are correct and true. I hereby consent to all necessary inspections made pursuant to the California Medical Waste Management Act and incidental to the issuance of this Registration/Permit and the operation of this business.

SIGNATURE: _____

DATE: _____