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| DH use only: Check No. _____ Check Amount _____ | |
| Date Received _____ | Receipt No. _____ |
| Permit No. _____ | Date Issued _____ |

Department of Health

Application for Biomedical Waste Generator Permit/Exemption

A biomedical waste generator is required to apply for an annual biomedical waste permit and abide by the requirements of Chapter 64E-16, Florida Administrative Code (F.A.C.). The initial permit fee is \$85.00. Permits expire September 30 of each year. The permit fee for renewal applications received by October 1 is \$85.00. The permit fee for renewal applications received after October 1 is \$105.00. State-owned and operated facilities are exempt from the permit fee. Submit the following information on this form to your local Department of Health Biomedical Waste Coordinator.

FOR CURRENTLY PERMITTED GENERATORS ONLY: A currently permitted biomedical waste generator, that produces **less than 25 pounds of biomedical waste** in each 30 day period, may claim an exemption from the fee and permitting requirements **only** of Chapter 64E-16, F.A.C. **A currently permitted biomedical waste generator applying for exemption from permitting must submit documentation from the previous 12 months showing the biomedical waste generated in each 30 day period during those 12 months was less than 25 lbs. Documentation must include the amount of waste generated in each 30 day period for the previous 12 months and may be in the form of a monthly log or receipts.**

- Application for (choose one):** _____ **Permit** _____ **Exemption (attach appropriate documentation)**
(Applicant must be a legal entity, i.e.: individual, partnership, corporation, association, or public body)
- Facility Name: _____
- Facility Address: _____
Street _____ City _____ State _____ Zip Code _____
- Contact Person: _____ Telephone: _____
- Name of Facility Owner: _____
- Mailing Address of Facility Owner: _____
Street _____ City _____ State _____ Zip Code _____
- Business Phone: _____ 24-Hour Emergency Phone: _____
- Name of Property Owner: _____
- Mailing Address of Property Owner: _____
Street _____ City _____ State _____ Zip Code _____
- Type of Waste Generated: _____ Sharps _____ Non-sharps
- Method of Removal (Check One): _____
1. By applicant, to where: _____
2. By transporter, company name: _____
- Maximum weight of biomedical waste generated during any 30-day period: _____ lbs.
- Branch Offices: _____ Yes _____ No If yes, attach sheet with complete name, address and phone number of branch office(s).

Check Type of Facility:

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|--|--|---|
| <input type="checkbox"/> 01. Hospital | <input type="checkbox"/> 07. Dentist | <input type="checkbox"/> 13. Surgical Center/Walk-in Clinic |
| <input type="checkbox"/> 02. Funeral Home | <input type="checkbox"/> 08. Podiatrist | <input type="checkbox"/> 14. Blood Banks |
| <input type="checkbox"/> 03. Dialysis Clinic | <input type="checkbox"/> 09. Osteopath | <input type="checkbox"/> 16. Abortion Clinics |
| <input type="checkbox"/> 04. Nursing Home | <input type="checkbox"/> 10. Home Health | <input type="checkbox"/> 17. Other (specify) |
| <input type="checkbox"/> 05. Veterinarian | <input type="checkbox"/> 11. State Laboratory/Clinic | <input type="checkbox"/> 18. Tattoo/Body Piercing |
| <input type="checkbox"/> 06. Medical Doctor | <input type="checkbox"/> 12. Clinical Laboratory | |

The undersigned owner/owner's representative hereby agrees to operate the biomedical waste generating facility described in this application in accordance with the requirements of Section 381.0098, Florida Statutes, and Chapter 64E-16, F.A.C. The information contained in this application, which serves as a basis for permitting or exemption, is true and correct. I understand that any misrepresentation of the facts in this application, or failure to comply with sanitary standards, is grounds for denial, administrative fine or revocation of the biomedical waste permit or exemption. Biomedical waste shall be handled within the facility in accordance with the generator's written operating plan. Operating plan must be in compliance with 64E-16, F.A.C.

Signature of Authorized Representative Name of Authorized Representative (print or type) Date