Department of Health
Application for Biomedical Waste Needle Collection Program Permit

Permits expire on September 30 of each year. Permits must be renewed annually. Submit the following information on this form to the county health department that has jurisdiction for the biomedical waste program in the county where the needles are collected.

1. Program Status: _____ New _____ Renewal

2. Facility Name: ________________________________________________________________

3. Facility Address: _____________________________________________________________
   Street  City  State  Zip Code

4. Contact Person: __________________________________ Telephone: ( ) ______________

5. Mailing Address of Contact: _________________________________________________
   Street  City  State  Zip Code

6. Business Phone: ( ) ______________

7. 24-Hour Emergency Phone: ( ) ______________

8. List all collection facilities intended for coverage under this permit, including the street address and city, state, zip code and phone number (attach additional sheets if necessary):
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________

9. Describe how the program will function or operate (attach additional sheets if necessary):
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________

10. Describe where biomedical waste will be stored and treated:
    __________________________________________________________________________________
     __________________________________________________________________________________
     __________________________________________________________________________________

11. Beginning date of program: ____________________________

Certification:

To the best of my knowledge and belief, I certify that I understand and will comply with the applicable requirements of Chapter 64E-16, F.A.C., and that the information provided in this notification is true and accurate.

________________________________________  ________________________________  __________
Signature of Authorized Representative  Name of Authorized Representative (print or type)  Date

DH 4108, 8/98