Regulated Medical Waste Management Facility PBR Application Form

Please specify, is this application for a ☐ New Facility or ☐ PBR Modification

I. FACILITY INFORMATION

A. Facility Information

Facility Name: _____ **Permit No. PBR**_____
Location Address: _____
City, State, Zip: _____
Latitude: _____ Deg _____ Min _____Sec North **Longitude:** _____ Deg _____ Min _____Sec West
Tax Map, Parcel ID: _____ **County:** _____
Total Property Acreage: _____ acres **RMW Management Area:** _____ square feet

B. Facility Contact Information

Contact Person: _____ **Contact Title:** _____
Contact Phone: _____ **Contact E-mail:** _____

Owner: _____ **Operator:** _____
Mailing Address: _____ **Mailing Address:** _____
City, State, Zip: _____ **City, State, Zip:** _____

C. Regulated Medical Waste Generation

Where is RMW Generated? : ☐ Onsite ☐ Offsite ☐ Both

RMW Source (check all that apply):

- ☐ Dentist's Office, Clinic, Oral Surgery Center, or similar Dental Facility
- ☐ Doctor's Office, Clinic, Hospital, or similar Health Care Facility
- ☐ Nursing Home, Assisted Living, or Home Health Facility
- ☐ Research Facility, Diagnostic Laboratory, or similar
- ☐ University or Educational facility
- ☐ Veterinarian Practice, Animal Research, or similar Animal Care Facility
- ☐ Other, please specify: _____

RMW Facility Type (check all that apply):

- ☐ Transfer Station
- ☐ Treatment

Facility Process Rate: _____ (include units as weight or volume per day)

RMW Storage Capacity: _____ Specify Units **Treated Waste Storage Capacity:** _____ Specify Units

Is Refrigerated RMW Storage available? ☐ Yes ☐ No

Is there a Reusable Cart Washing Station? ☐ Yes ☐ No

Disposition of Treated or Transferred Wastes: _____

Hours of Operation: _____

II. TREATMENT UNIT INFORMATION

Fill out a separate Section II for each treatment unit located at the facility.

A. Treatment Unit Specifics ☐ N/A

Device Trade Name: _____ Unit _____ of _____

Model Number:_____

Unit Location: _____

Treatment Type:

☐ Alkaline Hydrolysis ☐ Autoclave ☐ Chemical Treatment

☐ Dry Heat Treatment ☐ Incineration ☐ Microwave

☐ Alternate Treatment, specify: _____

Treatment Indicator Parameters: (check all that apply)

Indicator Parameter	Operation Setting	Recording Method
☐ **Temperature:**		Specify
☐ **Pressure:**		Specify
☐ **Time:**		Specify
☐ **Chemical Concentration:**		Specify

☐ Other (Please specify): _____

Proposed Biological Indicator: _____

Treatment Cycle Time: _____ Specify Units

Max Loading Rate per cycle: _____ Specify Units

B. Types of RMW to be Treated (check all that apply)

☐ Animal carcasses or body parts

☐ Animal bedding and related wastes

☐ Category A wastes

☐ Chemo and/or Radioactive Wastes (transfer only)

☐ Cultures and Stocks

☐ Human blood and body fluids

☐ Human pathological and anatomical waste

☐ Other Wastes, please list: _____

☐ Mixed RMW and solid waste

☐ Non-hazardous Pharmaceuticals

☐ Prion waste

☐ Residues

☐ Sharps

☐ Solidified liquids

☐ Toxins or toxin waste solutions

C. Wastewater Management (check all that apply)

☐ Discharged directly to WWTP

☐ Treated onsite and discharged

☐ Transported by vehicle to offsite WWTP

☐ Other, please specify: _____

III. TRANSFER STATION

A. Types of RMW to be Transferred (check all that apply) ☐ N/A

- ☐ Animal carcasses or body parts
- ☐ Animal bedding and related wastes
- ☐ Category A wastes
- ☐ Chemo and/or Radioactive Wastes (transfer only)
- ☐ Cultures and Stocks
- ☐ Human blood and body fluids
- ☐ Human pathological and anatomical waste
- ☐ Other Wastes, please list: ______
- ☐ Mixed RMW and solid waste
- ☐ Non-hazardous Pharmaceuticals
- ☐ Prion waste
- ☐ Residues
- ☐ Sharps
- ☐ Solidified liquids
- ☐ Toxins or toxin waste solutions

B. Wastewater Management (check all that apply)

- ☐ Discharged directly to WWTP
- ☐ Treated onsite and discharged
- ☐ Transported by vehicle to offsite WWTP
- ☐ Other, please specify: ______

IV. PBR APPLICATION ATTACHMENTS

The following items shall be provided as an attachment to this form and will constitute the facility's Permit-by-Rule application. Please indicate whether each item is 'provided' or 'not applicable' to the proposed facility or facility modification.

Permit-by-Rule Application Attachment	Provided	N/A
A. Notice of Intent	☐	☐
1. Disclosure Statement, DEQ Forms DISC-01 and DISC-02	☐	☐
2. Waste Management Facility Operator Certification	☐	☐
3. Local Government Certification and Solid Waste Management Plan Consistency Certification, DEQ Form CERT-01	☐	☐
4. Public Participation Summary	☐	☐
B. Certification of Siting Standards, 9 VAC 20-121-210	☐	☐
C. P.E. Certification of Design/Construction Standards, 9 VAC 20-121-220	☐	☐
D. Design Plans, 9 VAC 20-121-310.A.2.d.	☐	☐
E. Documentation of authorization to discharge to Sanitary Sewer / POTW	☐	☐
F. Certification that the Facility meets the Standards of Part III (9VAC20-121-100 et seq.) and Part IV (9VAC20-121-200 et seq.), as applicable	☐	☐
1. Copy of the Regulated Medical Waste Management Plan in accordance with 9VAC20-121-330	☐	☐
2. Statement that the Emergency Contingency Plan has been provided to the local police and fire departments, local emergency manager, and a local emergency health coordinator	☐	☐
G. Alternate Treatment Technology Approval	☐	☐
H. Treatment Plan, 9 VAC 20-121-330.E.	☐	☐
I. For Treatment Facilities, a Treated Waste Disposal Plan, 9 VAC 20-121-280.D.	☐	☐
J. Closure Plan, 9 VAC 20-121-330.G.	☐	☐
K. Demonstration of legal control over the site	☐	☐
L. State Corporation Commission Certification	☐	☐
M. Closure Cost Estimate and Proof of Financial Assurance	☐	☐
N. Permit Fee specified under 9 VAC 20-90	☐	☐
O. Copies of other DEQ Media Permits (Air, VPDES, etc.)	☐	☐
P. Variance Petition in accordance with 9 VAC 20-121-400 If provided, please indicate the regulatory citation for variance: ______	☐	☐

V. RESPONSIBLE OFFICIAL SIGNATURE

I certify under penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system or those persons directly responsible for gathering the information, the information submitted is to the best of my knowledge and belief true, accurate, and complete.

SIGNATURE: ____ DATE: ____________________

NAME: ____

TITLE: ____