ANNUAL REPORT

This Regulated Medical Waste Facility Annual Report is for the year of operation from January 01, 2019 to December 31, 2019

SECTION 1 – FACILITY INFORMATION

FACILITY INFORMATION

FACILITY NAME: Cardinal Health Nuclear and Precision Health Solutions

FACILITY LOCATION ADDRESS:	FACILITY CITY:	STATE:	ZIP CODE:
6075 East Molloy Roa	Syracuse	NY	13211

FACILITY TOWN:	FACILITY COUNTY:	FACILITY PHONE NUMBER:
Dewitt	Onondaga	315-437-9845

FACILITY NYS PLANNING UNIT: (A list of NYS Planning Units can be found at the end of this report).	NYSDEC REGION #:
Onondaga County (except Skaneateles (T) & (V))	7

360 PERMIT #:	DATE ISSUED:	DATE EXPIRES:	NYS DEC ACTIVITY CODE OR REGISTRATION NUMBER:
7-3126-138/0000	09/26/17	09/25/24	34H01

FACILITY CONTACT:		CONTACT PHONE NUMBER:	CONTACT FAX NUMBER:
Gary Mantz	☒ public ☐ private	315-437-9845	315.437.0617

CONTACT EMAIL ADDRESS:

OWNER INFORMATION

OWNER NAME:	OWNER PHONE NUMBER:	OWNER FAX NUMBER:
Cardinal Health	614.757.5000	

OWNER ADDRESS:	OWNER CITY:	STATE:	ZIP CODE:
7000 Cardinal Place	Dublin	OH	43017

OWNER CONTACT:	OWNER CONTACT EMAIL ADDRESS:
Dan Hill	dan.hill@cardinalhealth.com

OPERATOR INFORMATION

OPERATOR NAME: ☑ *same as owner* — ☒ public ☐ private

PREFERENCES

Preferred address to receive correspondence: ☒ *Facility location address* ☐ *Owner address* ☐ *Other (provide):*

Preferred email address: ☒ *Facility Contact* ☐ *Owner Contact* ☐ *Other (provide):*

Preferred individual to receive correspondence: : ☒ *Facility Contact* ☐ *Owner Contact* ☐ *Other (provide):*

Did you operate in 2019? ☒ Yes; Complete this form.

☐ No; Complete and submit Sections 1 and 10. If you no longer plan to operate and wish to relinquish your permit/registration associated with this solid waste management activity, also complete the "Inactive Solid Waste Management Facility or Activity Notification Form" located at: http://www.dec.ny.gov/chemical/52706.html .

SECTION 2 – PERMITTED RMW WASTE TRANSFER OR TREATMENT FACILITIES

	AMOUNT GENERATED OR RECEIVED FOR PROCESSING (tons)	AMOUNT TRANSFERRED TO TREATMENT FACILITY (tons)	AMOUNT TREATED (tons)	AMOUNT BYPASSED (tons)	AMOUNT OF SHARPS OR DEVICES PROCESSED FOR RECYCLING (tons)	IF WASTE IS TRANSFERRED, THE NAME AND ADDRESS OF TRANSFER OR TREATMENT FACILITY (Include county and state)	NYS PLANNING UNIT (See Attached List of NYS Planning Units)
RMW (Including: Cultures and Stocks, Human Pathological Waste, Human Blood and Blood Products, Sharps, and Animal Waste)	0.048	0.048 ←				Stericycle inc 3472 Progress DR Dunkirk, NY 14048	Chautauqua County
Other Infectious Waste (specify amount for each contaminated material including infectious incident waste, human remains management waste, etc.)							
Radioactive Waste (specify for each very short lived, short lived or long lived)	1.41 (VSL) 0.0695(LL)	1.1364(VSL) 0.0595(LL)				Stericycle inc 3472 Progress Dr. Dunkirk, NY 14048	Chautauqua County
Pharmaceutical Waste							
Hazardous Waste							
Other (specify amount for each material including hydrolysate, ash, C&D, etc. requiring further processing.)							
TOTAL	1.527						

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SECTION 3 – DISPOSAL DESTINATION

WASTE TYPE	AMOUNT (tons)	FACILITY NAME AND ADDRESS	STATE	COUNTY	NYS PLANNING UNIT (See Attached List of NYS Planning Units)
Treated Waste					
TOTAL WASTE					

SECTION 4 – UNAUTHORIZED SOLID WASTE

Has unauthorized solid waste been received at the facility during the reporting period? ☐ Yes ☑ No

If yes, give information below for each incident (attach additional sheets if necessary):

Date Received	Type Received	Date Disposed	Disposal Method & Location

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SECTION 5 - COST ESTIMATES AND FINANCIAL ASSURANCE DOCUMENTS

Are there required cost estimates and financial assurance documents for closure?

☐ Yes ☑ No If yes, attach additional sheets reflecting annual adjustments for inflation and any changes to the Closure Plan?

SECTION 6 – PROBLEMS

Were any problems encountered during the reporting period (e.g., specific occurrences which have led to changes in facility procedures)?

☐ Yes ☑ No If yes, attach additional sheets identifying each problem and the methods for resolution of the problem.

SECTION 7 – CHANGES

Were there any changes from approved reports, plans, specifications, and permit conditions?

☐ Yes ☑ No If yes, attach additional sheets identifying changes with a justification for each change.

SECTION 8 - PERMIT/CONSENT ORDER REPORTING REQUIREMENTS

Are there any additional permit/consent order reporting requirements not covered by the previous sections of this form?

☐ Yes ☑ No If yes, attach additional sheets identifying the reporting requirements with their respective responses.

SECTION 9 - SIGNATURE AND DATE BY OWNER OR OPERATOR

Owner or Operator must sign, date and submit the completed form by email or mail to the appropriate Regional Office (See attachment for Regional Office email & mailing addresses and Solid Waste Contacts.)

The Owner or Operator must also submit one copy by email, fax or mail to:

New York State Department of Environmental Conservation
Division of Materials Management
Bureau of Permitting and Planning
625 Broadway
Albany, New York 12233-7260
Fax 518-402-9041
Email address: SWMFannualreport@dec.ny.gov

I hereby affirm under penalty of perjury that information provided on this form and attached statements and exhibits was prepared by me or under my supervision and direction and is true to the best of my knowledge and belief, and that I have the authority to sign this report form pursuant to 6 NYCRR Part 360. I am aware that any false statement made herein is punishable as a Class A misdemeanor pursuant to Section 210.45 of the Penal Law.

Signature

1/28/2020
Date

Gary Mantz
Name (Print or Type)

Pharmacist
Title (Print or Type)

gary.mantz@cardinalhealth.com
Email (Print or Type)

6075 E Molloy Rd
Address

Syracuse
City

NY 13211
State and Zip

(31[illegible]) 98[illegible]-9847
Phone Number

ATTACHMENTS: ☐ YES ☑ NO

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