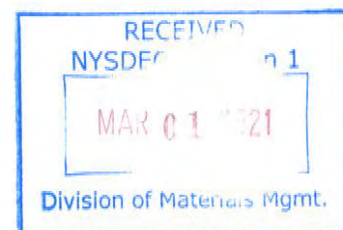


Wade

Division of Materials Management
New York State Department of Environmental Conservation
Albany, New York 12233-7260

REGULATED MEDICAL WASTE FACILITIES

Annual Report



Submit the Annual Report no later than March 1, 2021.

Reporting of the information indicated on this Regulated Medical Waste Annual Report form is required pursuant to 6 NYCRR 360-1.4(c); 360-1.8(e)(1)(ii), (h)(8); 360-1.14(e)(2), (l)(1); 360-11.1(a), (b)(1)(viii); 360-11.4(h) and (j); 360-17.4(e)(2),(e)(3);. Failure to provide the required information requested is a violation of Environmental Conservation Law. Timely submission of a properly completed form to the Department's Regional Office that has jurisdiction over your facility and to the Department's Central Office is required to meet the Annual Report requirements of 6 NYCRR Part 360 and Part 365.

Where the Annual Report requirements have been modified, appropriate Sections (as necessary to reflect the modification) must be completed and submitted with a copy of the Department's written notification which allows the modification.

Entries on the report forms should be either typewritten or neatly printed in black ink. Attach additional sheets if space on the pages is insufficient or supplementary information is required or appropriate.

INSTRUCTIONS FOR COMPLETING THE FORM:

SECTION 1: Provide facility information and identify whether the facility operated waste during the year.

SECTION 2: Identify the amount of each type of waste generated and treated on-site (if a generator permitted to treat on-site), or if a commercial facility, the amount received by the facility from the generators and how it was processed. If transferred off-site by the generator or if a transfer facility, identify the treatment facility where the waste was sent.

SECTION 3: If a treatment facility, identify the names and addresses of disposal facilities where treated waste was disposed.

SECTION 4: Identify any unauthorized waste that was received at the facility.

SECTION 5: If required, provide updated cost estimates and financial assurance documentation.

SECTION 6: Identify any problems which occurred at the facility.

SECTION 7: Identify any changes from the approved permit or permit documentation.

SECTION 8: Identify any additional permit or consent order reporting requirements.

SECTION 9: Sign and date the form and follow the instructions provided for submission of form.

REGULATED MEDICAL WASTE FACILITY ANNUAL REPORT

This Regulated Medical Waste Facility Annual Report is for the
year of operation from January 01, 2020 to December 31, 2020

SECTION 1 – FACILITY INFORMATION

FACILITY INFORMATION				RECEIVED NYSDEC - Region 1 <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 5px auto;">MAR 01 2021</div> Division of Materials Management	
FACILITY NAME: RLS (USA) Inc					
FACILITY LOCATION ADDRESS: 80 Seaview Blvd		FACILITY CITY: Port Washington		STATE: NY	ZIP CODE: 11050
FACILITY TOWN: North Hempstead		FACILITY COUNTY: Nassau		FACILITY PHONE NUMBER: 516-626-2799	
FACILITY NYS PLANNING UNIT: (A list of NYS Planning Units can be found at the end of this report). North Hempstead SWMA					NYSDEC REGION #: 1
360 PERMIT #:	DATE ISSUED: 9/8/2020	DATE EXPIRES: 9/07/2025	NYS DEC ACTIVITY CODE OR REGISTRATION NUMBER: 30J10120		
FACILITY CONTACT: David Blanchard		<input checked="" type="checkbox"/> public <input type="checkbox"/> private	CONTACT PHONE NUMBER: 516-626-2799		CONTACT FAX NUMBER: 516-621-5807
CONTACT EMAIL ADDRESS: David.Blanchard@rls.bio					
OWNER INFORMATION					
OWNER NAME: Rinsi Chacko		OWNER PHONE NUMBER: 516-626-2799		OWNER FAX NUMBER: 516-621-5807	
OWNER ADDRESS: 80 Seaview Blvd		OWNER CITY: Port Washington		STATE: NY	ZIP CODE: 11050
OWNER CONTACT: Rinsi Chacko		OWNER CONTACT EMAIL ADDRESS: Rinsi.Chacko@rls.bio			
OPERATOR INFORMATION					
OPERATOR NAME: <input checked="" type="checkbox"/> same as owner				<input checked="" type="checkbox"/> public <input type="checkbox"/> private	
PREFERENCES					
Preferred address to receive correspondence: <input checked="" type="checkbox"/> Facility location address <input type="checkbox"/> Owner address <input type="checkbox"/> Other (provide):					
Preferred email address: <input checked="" type="checkbox"/> Facility Contact <input type="checkbox"/> Owner Contact <input type="checkbox"/> Other (provide):					
Preferred individual to receive correspondence: <input checked="" type="checkbox"/> Facility Contact <input type="checkbox"/> Owner Contact <input type="checkbox"/> Other (provide):					

Did you operate in 2020? 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)	3.005	0.2125				Stericycle Inc., Oneonta, NY	Otsego County
		1.2075				Stericycle Inc., Warren, OH	N/A
		1.345				Curtis Bay Energy, Baltimore, MD	N/A
		0.215				Stericycle Inc., Woonsocket, RI	N/A
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)							
Pharmaceutical Waste							
Hazardous Waste							
Other (specify amount for each material including hydrolysate, ash, C&D, etc. requiring further processing.)							
TOTAL	3.005						

SECTION 3 – DISPOSAL DESTINATION

WASTE TYPE	AMOUNT (tons)	FACILITY NAME AND ADDRESS	STATE	COUNTY	NYS PLANNING UNIT <small>(See Attached List of NYS Planning Units)</small>
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

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.

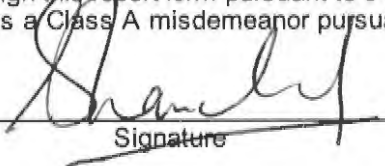
SECTION 9 - SIGNATURE AND DATE BY OWNER OR OPERATOR

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

2-24-2021
Date

David Blanchard
Name (Print or Type)

RSO
Title (Print or Type)

David.Blanchard@rls.bio
Email (Print or Type)

80 Seaview Blvd
Address

Port Washington
City

NY, 11050
State and Zip

516) 626 _2799
Phone Number

ATTACHMENTS: YES NO



February 23, 2021

Ms. Jie Zhao
NY State Department of Environmental Conservation
Division of Solid & Hazardous Materials, Region One
Building 40 – SUNY
Stony Brook, New York 11790-2356

RE: Financial Assurance Reporting for Registration No. 30J10120

Dear Ms. Zhao:

RLS (USA) Inc. would like to submit this correspondence to satisfy Section 5 of the annual report regarding the adjustment of facility closure costs due to inflation.

As required by section 5, RLS (USA) Inc. is to adjust the closure cost estimate so as not to exceed our credit limit. The attached table shows that taking into account Implicit Price Deflator adjustments issued by the U.S. Department of Commerce, RLS (USA) Inc. has not exceeded our financial surety credit limit year to date.

RLS (USA) Inc. currently holds a financial surety bond in the amount of \$ 105,000.00 for this registration. The cost has been calculated to be \$ 87,814.21. If you are in need of any additional information or clarification regarding the above mentioned items, please contact me @ 516. 626.2799 or by email @ David.Blanchard@rls.bio.

Regards,

A handwritten signature in black ink, appearing to read "Blanchard", with a long horizontal flourish extending to the right.

David Blanchard
Radiation Safety Officer

RLS (USA) Inc. Port Washington Facility Registration No. 30J10120

1. NY DEC annual report section 5 specifies an attachment be made to the annual report reflecting annual adjustments for inflation and any changes to the closure plan. adjustment have been made by recalculating the maximum cost of closure in current dollars, or by using an inflation factor derived from the most recent Implicit Price Deflator for Gross National Product published by the U.S. Department of Commerce in its Survey of Current Business. The inflation factor is the result of dividing the latest published annual deflator by the deflator for the previous year. The first adjustment is made by multiplying the closure cost estimate by the inflation factor. Subsequent adjustments are made by multiplying the latest closure cost estimate by the latest inflation factor".
2. Gross Domestic Product: Implicit Price Deflator (U.S. Department of Commerce: Bureau of Economic Analysis) table was used. The table was aquired from <https://research.stlouisfed.org/fred2/data/GDPDEF.txt>
3. The inflation factor was determined by dividing the latest infliation factor obtained from the IPD table and the inflation value used in generating the original cost closure estimate.
4. The closure cost estimate provided in the 2020 application was \$62,490.26

Finanical Assurance Closure Cost Estimate	<u>Previous Year's adjusted Closure Cost</u>	<u>Current Year's Adjusted Cost</u>
		\$85,550.00
	<u>Inflation Date</u>	<u>Inflation Value</u>
	1/1/2019	111.424
Latest Inflation Value	10/1/2020	114.373
Calculated Inflation Factor	1.02646647	

A surety bond must be worded exactly as follows, except that instructions in brackets are to be replaced with the relevant information and the brackets deleted:

SURETY BOND
(Financial Guarantee Bond)

Bond Number:

107285914

Date bond executed:

September 1, 2020

[If more than one Surety, identify bond number with respective Surety]

Effective date:

September 1, 2020

Principal: RLS (USA) Inc., 8345 NW 66th Street, Suite 6479, Miami, FL 33166

[Legal name and business address of owner or operator]

Type of organization: Corporation

[Insert "individual," "joint venture," "partnership," or "corporation"]

State of Incorporation: Delaware

Surety(ies): Travelers Casualty and Surety Company of America, 360 Granite Street, Suite 1201, Braintree, MA 02184

[Name(s) and business address(es) of Surety(ies)]

Obligee: New York State Department of Environmental Conservation (hereinafter referred to as "Department")

Department identification numbers, name, address, and closure, post-closure, custodial care, and/or corrective measures amount(s) for each facility guaranteed by this bond [indicate facility and closure, post-closure, custodial care and corrective measures amounts separately]:

Waste Bond

Total penal sum of bond: \$ 105,000.00 (payable in good and lawful money of the United States of America)

Total penal sum of bond: \$ 105,000.00 (payable in good and lawful money of the United States of America)

NOW, THEREFORE, Know All Persons By These Presents, that we, the Principal and Surety(ies) hereto are held and firmly bound to the Department in the above penal sum for the payment of which we bind ourselves, our heirs, executors, administrators, successors, and assigns jointly and severally; provided that, where the Surety(ies) are corporations acting as co-sureties, we, the Sureties, bind ourselves in such sum "jointly and severally" only for the purpose of allowing a joint action or actions against any or all of us, and for all other purposes each Surety binds itself, jointly and severally with the Principal, for the payment of such sum only as is set forth opposite the name of such Surety, but if no limit of liability is indicated, the limit of liability shall be the full amount of the penal sum.

WHEREAS said Principal is required, under Environmental Conservation Law (ECL) Article 27, to have a permit in order to operate each solid waste management facility identified above; and

WHEREAS said Principal is required to provide financial assurance for closure, post-closure care, custodial care and/or corrective measures as referred to above, as a condition of the permit(s); and

WHEREAS said Principal shall establish a standby trust fund as is required when a surety bond is used to provide such financial assurance;

NOW, THEREFORE, the conditions of the obligation are such that if the Principal shall faithfully perform and complete [insert "closure", "post-closure care", "custodial care", "and/or corrective measures"] whenever required to do so at each facility for which this bond guarantees payment for ["closure", "post-closure care", "custodial care" "and/or corrective measures"] in accordance with the ["closure plan", "post-closure care plan", "custodial care plan" "and/or corrective measures plan"] and other requirements of the permit, applicable rules, regulations, and orders of the department, and applicable provisions of the laws of the State of New York,

OR, if the Principal shall faithfully, before the beginning of final closure of each facility for which this bond guarantees payment, fund the standby trust fund in the amount(s) identified above for each facility,

OR, if the Principal shall fund the standby trust fund in such amount(s) within 15 days after an order to begin closure is issued by the Commissioner of the New York State Department of Environmental Conservation or the Commissioner's duly appointed designee (hereinafter referred to as the "Commissioner") or a United States district court or other court of competent jurisdiction,

OR, if the Principal shall provide alternate financial assurance, as identified in 6 NYCRR Section 360.22(d), as applicable, and obtain the Commissioner's written approval of such assurance, within 90 days after the date notice of cancellation is received by both the Principal

and the Department from the Surety(ies), then this obligation shall be null and void, otherwise it is to remain in full force and effect.

The Surety(ies) shall become liable on this bond obligation only when the Principal has failed to fulfill the conditions described above. Upon notification by the Commissioner that the Principal has failed to perform as guaranteed by this bond, the Surety(ies) shall provide funds up to the amount guaranteed for the facility(ies) into the standby trust fund or as otherwise directed by the Commissioner.

The liability of the Surety(ies) shall not be discharged by any payment or succession of payments hereunder, unless and until such payment or payments shall amount in the aggregate to the penal sum of the bond, but in no event shall the obligation of the Surety(ies) hereunder exceed the amount of said penal sum.

The Surety(ies) hereby waive(s) notifications of amendments to closure, post-closure, custodial care and/or corrective measures plans, permits, applicable laws, statutes, rules, and regulations and agrees that no such amendment shall in anyway alleviate the Surety's obligation on this bond.

The Surety(ies) may cancel the bond by sending notice of cancellation by certified mail, return receipt requested, to the Principal and the Commissioner, provided, however, that cancellation shall not occur during the 120 days beginning on the date of receipt of the notice of cancellation by both the Principal and the Commissioner, as evidenced by the return receipts.

The Principal may terminate this bond by sending written notice to the Surety(ies), provided, however, that no such notice shall become effective until the Surety(ies) receive(s) written authorization for termination of the bond by the Commissioner.

Principal and Surety(ies) hereby agree to adjust the penal sum of the bond yearly so that it guarantees the current closure, post-closure and/or corrective measures amount, provided that no decrease in the penal sum takes place without the written permission of the Commissioner.

IN WITNESS WHEREOF, the Principal and Surety(ies) have affixed their seals on the date set forth above.

The persons whose signatures appear below hereby certify that they are authorized to execute this surety bond on behalf of the Principal and Surety(ies) and that the wording of this surety bond is identical to the wording identified in 6 NYCRR Section 360.22(e)(4), as such regulations were constituted on the date this bond was executed.

PRINCIPAL RLS (USA) Inc.

(Signature(s)) _____

(Name(s)) _____

CORPORATE SURETY(IES) Travelers Casualty and Surety Company of America

[Name and Address] 350 Granite Street, Suite 1201, Braintree, MA 02184

State of Incorporation: Connecticut

Liability Limit: (For each facility, and in the aggregate)

\$ 670,641,000.00

(Signature(s)) *Laurie A. Penniman*

(Name(s) and Title(s)) Laurie A. Penniman, Attorney in-fact

(Corporate Seal)

[For every co-surety, provide signature(s), corporate seal if appropriate, and other information in the same manner as for Surety above.]

Bond Premium: \$ 2,100.00

(ACKNOWLEDGMENT BY PRINCIPAL, UNLESS IT BE A CORPORATION)

STATE OF _____ :
COUNTY OF _____ : SS.:

On this _____ day of _____, 20____, before me personally came _____ to me known and known to me to be the person(s) described in and who executed the foregoing instrument and acknowledged that (s)he executed the same.

Notary Public

(ACKNOWLEDGMENT BY PRINCIPAL, IF A CORPORATION)

STATE OF _____ :
COUNTY OF _____ : SS.:

On this _____ day of _____, 20____, before me personally came _____, to me known, who, being by me duly sworn, did depose and say that (s)he resides in _____; that (s)he is the _____ of _____, the corporation described in and which executed the within instrument; that (s)he knows the seal of said corporation; that the seal affixed to said instrument was such corporate seal; that it was so affixed by order of the Board of Directors of said corporation, and that (s)he signed his/her name thereto by like order.

Notary Public

(ACKNOWLEDGMENT BY SURETY COMPANY; PREPARE SEPARATE ACKNOWLEDGMENT FOR EACH SURETY)

STATE OF Massachusetts :
COUNTY OF Worcester : SS.:

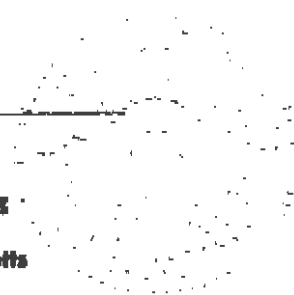
On this 1st day of September, 2020, before me personally came Laurie A. Penniman, to me known, who, being by me duly sworn, did depose and say that (s)he resides in Marlborough, MA; that (s)he is the Attorney-in-fact of Travelers Casualty and Surety Company of America, (insert name of Surety), the corporation described in and which executed the within instrument; that (s)he knows the seal of said corporation; that the seal affixed to said instrument is such corporate seal; that it was so affixed by order of the Board of Directors of said corporation, and that (s)he signed his/her name thereto by like order; and that the liabilities of said company do not exceed its assets as ascertained in the manner provided by the laws of the State of New York.



Notary Public



COURTNEY ELLEN COLLINS
Notary Public
Commonwealth of Massachusetts
My Commission Expires
January 23, 2026





**Travelers Casualty and Surety Company of America
Travelers Casualty and Surety Company
St. Paul Fire and Marine Insurance Company**

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS: That Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company are corporations duly organized under the laws of the State of Connecticut (herein collectively called the "Companies"), and that the Companies do hereby make, constitute and appoint **Laurie A. Penniman** of **Worcester Massachusetts**, their true and lawful Attorney-in-Fact to sign, execute, seal and acknowledge any and all bonds, recognizances, conditional undertakings and other writings obligatory in the nature thereof on behalf of the Companies in their business of guaranteeing the fidelity of persons, guaranteeing the performance of contracts and executing or guaranteeing bonds and undertakings required or permitted in any actions or proceedings allowed by law.
IN WITNESS WHEREOF, the Companies have caused this instrument to be signed, and their corporate seals to be hereto affixed, this 3rd day of February, 2017.



State of Connecticut
City of Hartford as.

By:
Robert L. Raney, Senior Vice President

On this the 3rd day of February, 2017, before me personally appeared **Robert L. Raney**, who acknowledged himself to be the Senior Vice President of Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company, and that he, as such, being authorized so to do, executed the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

In Witness Whereof, I hereunto set my hand and official seal.

My Commission expires the 30th day of June, 2021



Marie C. Tetreault, Notary Public

This Power of Attorney is granted under and by the authority of the following resolutions adopted by the Boards of Directors of Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company, which resolutions are now in full force and effect, reading as follows:

RESOLVED, that the Chairman, the President, any Vice Chairman, any Executive Vice President, any Senior Vice President, any Vice President, any Second Vice President, the Treasurer, any Assistant Treasurer, the Corporate Secretary or any Assistant Secretary may appoint Attorneys-in-Fact and Agents to act for and on behalf of the Company and may give such appointee such authority as his or her certificate of authority may prescribe to sign with the Company's name and seal with the Company's seal bonds, recognizances, contracts of indemnity, and other writings obligatory in the nature of a bond, recognizance, or conditional undertaking, and any of said officers or the Board of Directors at any time may remove any such appointee and revoke the power given him or her; and it is

FURTHER RESOLVED, that the Chairman, the President, any Vice Chairman, any Executive Vice President, any Senior Vice President or any Vice President may delegate all or any part of the foregoing authority to one or more officers or employees of this Company, provided that each such delegation is in writing and a copy thereof is filed in the office of the Secretary; and it is

FURTHER RESOLVED, that any bond, recognizance, contract of indemnity, or writing obligatory in the nature of a bond, recognizance, or conditional undertaking shall be valid and binding upon the Company when (a) signed by the President, any Vice Chairman, any Executive Vice President, any Senior Vice President or any Vice President, any Second Vice President, the Treasurer, any Assistant Treasurer, the Corporate Secretary or any Assistant Secretary and duly attested and sealed with the Company's seal by a Secretary or Assistant Secretary; or (b) duly executed (under seal, if required) by one or more Attorneys-in-Fact and Agents pursuant to the power prescribed in his or her certificate or their certificates of authority or by one or more Company officers pursuant to a written delegation of authority; and it is

FURTHER RESOLVED, that the signature of each of the following officers: President, any Executive Vice President, any Senior Vice President, any Vice President, any Assistant Vice President, any Secretary, any Assistant Secretary, and the seal of the Company may be affixed by facsimile to any Power of Attorney or to any certificate relating thereto appointing Resident Vice Presidents, Resident Assistant Secretaries or Attorneys-in-Fact for purposes only of executing and attesting bonds and undertakings and other writings obligatory in the nature thereof, and any such Power of Attorney or certificate bearing such facsimile signature or facsimile seal shall be valid and binding upon the Company and any such power so executed and certified by such facsimile signature and facsimile seal shall be valid and binding on the Company in the future with respect to any bond or understanding to which it is attached.

I, **Kevin E. Hughes**, the undersigned, Assistant Secretary of Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company, do hereby certify that the above and foregoing is a true and correct copy of the Power of Attorney executed by said Companies, which remains in full force and effect.

Dated this 1st day of September, 2020



Kevin E. Hughes, Assistant Secretary

To verify the authenticity of this Power of Attorney, please call us at 1-800-421-3880.
Please refer to the above-named Attorney-in-Fact and the details of the bond to which the power is attached.



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Cust-Site ID: 8322394-001

Route No: 435- 7



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

1. Generator's Name and Mailing Address

ATTN: RINSI CHACKO, .PH
RLS (USA) INC. FORT WASHINGTON
80 SEAVIEW BLVD
FORT WASHINGTON, NY 110504618

2. Tracking Form Number

MDLI005NLF

4. State Permit or ID No.

3. Telephone Number

(516) 626-2799

5. Transporter's Name and Mailing Address

STERICYCLE, INC
28161 North Keith Drive
Lake Forest, Illinois 60045

6. Telephone Number

8006339278

7. State Transporter or ID No(s).

IL-033

8. Destination Facility Name and Address

STERICYCLE INC.
31 Lower River Street
ONEONTA, NY 13820

9. Telephone Number

866-783-7422

10. State Permit or ID No.

4-3646-00034\00005

11. USDOT Shipping Name (or waste description)

HM

11a. Container Type

12. Total No. Containers

13. Total Volume

a.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	18	75.6	CF
b.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub			CF
c.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack			CF
d.		Regulated Medical Waste (Treated)				CF

14. Special Handling Instructions and Additional Information

10 WY45 = 18 9 WY45 = 15

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

Sewing Park [Signature] 12/3/2020
Print/Type Name Signature Date

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

Copy 1 – GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 – DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 – TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 – TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 – GENERATOR COPY – Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

Hector Barrientos [Signature] 12/3/2020
Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

TRANSPORTER

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)

Received in accordance with items 11, 12 & 13
M. Swift Michelle Swift 12/7/20
Print/Type Name Signature Date
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

DESTINATION

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Cust. Site ID: 8322394-001

Route No: 695- 7



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

1. Generator's Name and Mailing Address

ATTN: RINSI CHACKO, .PH
RLS (USA) INC. PORT WASHINGTO
80 SEAVIEW BLVD
PORT WASHINGTON, NY 110504618

3. Telephone Number

(516) 626-2799

5. Transporter's Name and Mailing Address

STERICYCLE, INC
28161 North Keith Drive
Lake Forest, Illinois 60045

8. Destination Facility Name and Address

STERICYCLE INC.
31 Lower River Street
ONEONTA, NY 13820

11. USDOT Shipping Name (or waste description)

	HM				
a.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	19	79.8 CF
b.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub		CF
c.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack		CF
d.		Regulated Medical Waste (Treated)			CF

14. Special Handling Instructions and Additional Information

PLU 19-WYER
0/019

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

MA/ANIS S. AGUIRRE
Print/Type Name Signature

11/5/2020 Date

2. Tracking Form Number

MDLI005LX8

4. State Permit or ID No.

6. Telephone Number

8006339278

7. State Transporter or ID No(s).

IL-033

9. Telephone Number

866-783-7422

10. State Permit or ID No.

4-3646-00034\00005

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

Copy 1 – GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 – DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 – TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 – TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 – GENERATOR COPY – Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

Julie Espinoza
Print/Type Name Signature Date 11/5/2020

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)
 Received in accordance with items 11, 12 & 13

Print/Type Name Signature Date
11/3/20

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

Box 8 = Stericycle Inc.
Box 9 = 1901 Pine Avenue SE
Box 10 = Warren OH 44483
330-393-0385
Permit# 0278080634

DESTINATION

GENERATOR

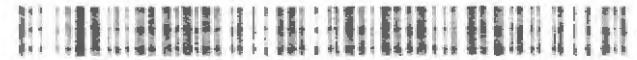
TRANSPORTER



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Dist. Site ID: 6307354-001

Route No. 695-7



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

Y. Espana *[Signature]*
Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)
 Received in accordance with items 11, 12 & 13

[Signature] *10/14/02*
Print/Type Name Signature Date
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

Storicycle Inc.
1801 Pine Avenue SE
Warren OH 44403
33088-0086
Permit # 0270000534

DESTINATION

TRANSPORTER

1. Generator's Name and Mailing Address

[Faded text]

3. Telephone Number

5. Transporter's Name and Mailing Address

[Faded text]

8. Destination Facility Name and Address

[Faded text]

11. USDOT Shipping Name (or waste description)

	HM		11a. Container Type	12. Total No. Containers	13. Total Volume	
a.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	25	105	CF
b.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub			CF
c.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack			CF
d.		Regulated Medical Waste (Treated)				CF

14. Special Handling Instructions and Additional Information

P/O 25-6411
P/O 25

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

JERRY ELKINS *[Signature]*
Print/Type Name Signature Date

2. Tracking Form Number

[Faded text]

4. State Permit or ID No.

IL-033

6. Telephone Number

[Faded text]

7. State Transporter or ID No(s).

9. Telephone Number

[Faded text]

10. State Permit or ID No.

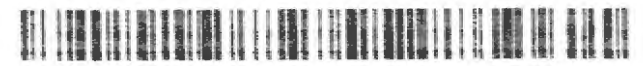
GENERATOR



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Cust Site ID: 9322394-001

Route No: 695- 8



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

GENERATOR

1. Generator's Name and Mailing Address ATTN: RINSI CHACKO, PH RLS (USA) INC. PORT WASHINGTON 80 SEAVIEW BLVD PORT WASHINGTON, NY 110504618		2. Tracking Form Number MDLI0051LR	
3. Telephone Number (516) 626-0799		4. State Permit or ID No.	
5. Transporter's Name and Mailing Address STERICYCLE, INC 28161 North Keith Drive Lake Forest, Illinois 60045		6. Telephone Number 8006339278	
8. Destination Facility Name and Address STERICYCLE INC. 31 Lower River Street ONEONTA, NY 13829		7. State Transporter or ID No(s) IL-033	
11. USDOT Shipping Name (or waste description) HM		9. Telephone Number 866-783-7422	
11a. Container Type Corrugated Box		10. State Permit or ID No. 4-3646/00034\00005	
12. Total No. Containers 20		13. Total Volume 84 CF	
a. <input checked="" type="checkbox"/> UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)		Corrugated Box	
b. <input checked="" type="checkbox"/> UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)		Reusable Tub	
c. <input checked="" type="checkbox"/> UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)		Wheeled Rack	
d. <input type="checkbox"/> Regulated Medical Waste (Treated)			

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

[Signature] *[Signature]* 9/17/2020
Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

Kandy Armstrong

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)

Received in accordance with items 11, 12 & 13

[Signature] 9/17/2020
Print/Type Name Signature Date
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

STERICYCLE, INC.
360 PARK EAST DRIVE
WOONSOCKET, RI 02895
PERMIT RI-053

14. Special Handling Instructions and Additional Information

p/c 20-448
D/CE

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

[Signature] *[Signature]*
Print/Type Name Signature Date 9/17/2020

DESTINATION



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Customer ID: 589419001

Route No: 895 5



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

1. Generator's Name and Mailing Address
GEN: RINSI DRACON, INC
LAW OF HEALTHCARE
NO SEAVIEW BLVD
PORT WASHINGTON, NY 110504618

2. Tracking Form Number
MDL10058WI

4. State Permit or ID No.

3. Telephone Number (916) 634-0749

5. Transporter's Name and Mailing Address
WHEELYBARK, INC
2000 North Keith Drive
Lake Forest, Illinois 60149

6. Telephone Number
848-270-0000

7. State Transporter or ID No(s)
IL-033

8. Destination Facility Name and Address
WHEELYBARK, INC
2000 North Keith Drive
Lake Forest, IL 60149

9. Telephone Number
848-270-0000

10. State Permit or ID No.
0203090000

11. USDOT Shipping Name (or waste description)		11a. Container Type	12. Total No. Containers	13. Total Volume
HM				
a.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated)	Corrugated Box	13	54.6 CF
b.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated)	Reusable Tub		CF
c.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated)	Wheeled Rack		CF
d.	Regulated Medical Waste (Treated)			CF

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)	18. Telephone Number
Print/Type Name: <u>Ramon Molina</u> Signature: <u>Ramon Molina</u> Date: <u>8/11/20</u>	
17. Transporter 2 or Intermediate Handler (Name and Address)	19. State Transporter or ID No(s).

14. Special Handling Instructions and Additional Information
Incineration
Plu (13) W445
D/O (15) W445

15. Generator's Certification
I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labeled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.
Jersey Ekins
Print/Type Name: Jersey Ekins Signature: Jersey Ekins Date: 8/11/20

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM
Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 - GENERATOR COPY - Retained by Generator (Gold)
1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

TRANSPORTER
20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)
Print/Type Name: _____ Signature: _____ Date: _____
21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION
22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)
 Received in accordance with items 11, 12 & 13
Jersey Ekins
Print/Type Name: _____ Signature: _____ Date: 8-11-20
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)
23. Discrepancy Box (Any discrepancies should be noted by item number and initials)



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Cust-Ste ID: 8098416-001

Route No. 895- 8



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

GENERATOR

1. Generator's Name and Mailing Address APPROX: RINAI CHACK... SUNSHINE HEALTH CARE 30 SEAVIEW BLVD WEST SPRINGFIELD, NY 12154		2. Tracking Form Number V01110101	
3. Telephone Number 516-223-2345		4. State Permit or ID No.	
5. Transporter's Name and Mailing Address WEST SPRINGFIELD, NY 1001 N. 10th Street Suite 1000 West Springfield, NY 12154		6. Telephone Number 516-223-2345	
8. Destination Facility Name and Address TECHNICAL INC. 1001 2nd Avenue WARREN, NY 14148		7. State Transporter or ID No(s). IL-033	
9. Telephone Number 516-223-2345		10. State Permit or ID No. 1001010101	
11. USDOT Shipping Name (or waste description) HM	11a. Container Type	12. Total No. Containers	13. Total Volume
a. <input checked="" type="checkbox"/> UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	24	100.8 CF
b. <input checked="" type="checkbox"/> UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub		CF
c. <input checked="" type="checkbox"/> UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack		CF
d. <input type="checkbox"/> Regulated Medical Waste (Treated)			CF

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

TRANSPORTER

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

Ramon Lopez *Ramon Lopez* 7/13/20
Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)

Received in accordance with items 11, 12 & 13

John (M) Linceo 7-13-20
Print/Type Name Signature Date
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

14. Special Handling Instructions and Additional Information
Incineration
Plu @ 24-wyes
d/o @ 20-wyes

15. Generator's Certification
I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labeled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

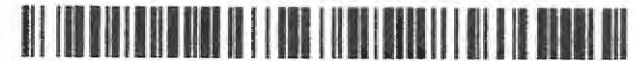
Victor Riquelme *[Signature]*
Print/Type Name Signature Date



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Cust-Site ID: 8098416-001

Route No: 295- 11



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

1. Generator's Name and Mailing Address
ATTN: RINSI CHACKO, .PH
RXW/GE HEALTHCARE
80 SEAVIEW BLVD
PORT WASHINGTON, NY 110504618

2. Tracking Form Number
MDLI005CAK

4. State Permit or ID No.

3. Telephone Number (516) 626-2799

5. Transporter's Name and Mailing Address
STERICYCLE, INC
28161 North Keith Drive
Lake Forest, Illinois 60045

6. Telephone Number
8006339278

7. State Transporter or ID No(s).
IL-033

8. Destination Facility Name and Address
STERICYCLE INC.
1901 Pine Avenue
WARREN, OH 44483

9. Telephone Number
866-783-7422

10. State Permit or ID No.
0278080634

11. USDOT Shipping Name (or waste description)
HM

11a. Container Type

12. Total No. Containers

13. Total Volume

a.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	19	79.8	CF
b.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub			CF
c.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack			CF
d.		Regulated Medical Waste (Treated)				CF

14. Special Handling Instructions and Additional Information
Incineration
plc @ 19-W445
d/c @ 30-W445

15. Generator's Certification
I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.
VICTOR RIQUELME
Print/Type Name Signature Date 6/11/2020

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM
Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 - GENERATOR COPY - Retained by Generator (Gold)
1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

TRANSPORTER

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)
Ramon Moran
Print/Type Name Signature Date 6/11/2020

17. Transporter 2 or Intermediate Handler (Name and Address)
18. Telephone Number
19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)
Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)
 Received in accordance with items 11, 12 & 13
TERRY WYSE
Print/Type Name Signature Date 6-11-2020
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

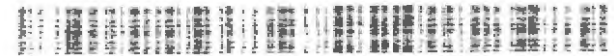
23. Discrepancy Box (Any discrepancies should be noted by item number and initials)



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Customer No. 2080478-000

Route No. 455-1



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

1. Generator's Name and Mailing Address

ATWY- RINSE SHACKS, INC
RINSE HEALTHCARE
80 BEAVEN BLVD
EAST WASHINGTON, NY 110504918

2. Tracking Form Number

WML0000001

4. State Permit or ID No.

3. Telephone Number

(800) 826-3787

5. Transporter's Name and Mailing Address

STERECYCLE, INC
26451 North Faith Court
Lake Forest, Illinois 60045

6. Telephone Number

815-899-0078

7. State Transporter or ID No(s).

IL-033

8. Destination Facility Name and Address

STERECYCLE, INC
1401 Pine Avenue
GARDEN, NY 11040

9. Telephone Number

307-852-8000

10. State Permit or ID No.

307-852-8000

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

- Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
- Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
- Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
- Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
- Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

- 1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
- 2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

Hector Barrientos *[Signature]* 5/7/20
Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

TRANSPORTER

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

[Signature] *[Signature]* *[Signature]*
Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)

Received in accordance with items 11, 12 & 13
[Signature] *[Signature]* *[Signature]* 5/13/20
Print/Type Name Signature Date
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

#8 **Curtis Bay Energy**
3200 Hawkins Point Road
Baltimore, MD 21226
#9 **Phone # (443) 692-2300**
#10 **Permit # 2017-WMI-0036**

DESTINATION

11. USDOT Shipping Name (or waste description)

HM

a.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	11a. Container Type	12. Total No. Containers	13. Total Volume
a.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	4	16.8 CF
b.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub		CF
c.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack		CF
d.		Regulated Medical Waste (Treated)			CF

11a. Container Type

12. Total No. Containers

13. Total Volume

14. Special Handling Instructions and Additional Information

MAY 15 2020

70 WYOMING, MD 21226 W45 = 4
Curtis Bay Energy

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

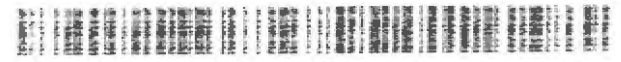
[Signature] *[Signature]* 5/7/2020
Print/Type Name Signature Date



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

West Side NY 8996418-001

Route No. 495-



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

1. Generator's Name and Mailing Address

ATW: FIRST ORBICO, PH
RHWGE HEALTHCARE
60 SPANVIEW BLVD
ROSE WASHINGTON, NY 118524412

2. Tracking Form Number

MEL10068970

4. State Permit or ID No.

3. Telephone Number

8281 626-8093

5. Transporter's Name and Mailing Address

EMERITROL, INC
29151 North Beach Drive
Lansford, Illinois 63045

6. Telephone Number

6015930276

7. State Transporter or ID No(s)

IL-033

8. Destination Facility Name and Address

EMERITROL, INC
1901 Pine Avenue
WARREN, NY 14260

9. Telephone Number

5857 753700

10. State Permit or ID No.

2073030724

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

- Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
- Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
- Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
- Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
- Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

- A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
- Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

HECTOR BARRIENTOS *[Signature]* 4/30/20
Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

TRANSPORTER

11. USDOT Shipping Name (or waste description)

11a. Container Type

12. Total No. Containers

13. Total Volume

HM				
a.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	4 16-8 CF
b.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub	CF
c.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack	CF
d.		Regulated Medical Waste (Treated)		CF

14. Special Handling Instructions and Additional Information

DESTROYED

MAY 10 2020

PU W445 = 4

PU W445 = 4 PARTIS BAY ENERGY

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

[Signature]
Print/Type Name 8996418-001

[Signature]
Signature Date

DESTINATION

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)

Received in accordance with items 11, 12 & 13
[Signature] 5720
Print/Type Name Signature Date
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

[Handwritten notes and signatures]



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Cust-Site ID: 3095415-001

Route No. 435- 65



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

- Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
- Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
- Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
- Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
- Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

- 1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
- 2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

TRANSPORTER

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

HECTOR BARRIENTOS
Print/Type Name: **DESTROYED** Signature: _____ Date: _____

17. Transporter 2 or Intermediate Handler (Name and Address)

MAY 01 2020
**CURTIS BAY ENERGY
BALTIMORE, MD 21226**

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)
 Received in accordance with items 11, 12 & 13

Blanch
Print/Type Name: _____ Signature: _____ Date: 9/29/20
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

#8 Curtis Bay Energy
3000 Hawkins Point Road
Baltimore, MD 21226
#7 Phone # (410) 371-1000
#11 Permit # 2011-1121-0000

GENERATOR

1. Generator's Name and Mailing Address

EMMA RINZI CHACKO, MD
EMMA'S HEALTHCARE
80 BEAVIEW BLVD
PORT WASHINGTON, NY 11050-6618

3. Telephone Number

(516) 626-0795

5. Transporter's Name and Mailing Address

STERICYCLE, INC
26151 North Keith Drive
Lake Forest, Illinois 60045

8. Destination Facility Name and Address

STERICYCLE, INC
1901 Five Avenue
WARREN, OH 44080

11. USDOT Shipping Name (or waste description)

HM

11a. Container Type

12. Total No. Containers

13. Total Volume

a. UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)

Corrugated Box

4

16.8

CF

b. UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)

Reusable Tub

CF

c. UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)

Wheeled Rack

CF

d. Regulated Medical Waste (Treated)

CF

14. Special Handling Instructions and Additional Information

% WY45 = 4 % WW45 = 4

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labeled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

DAVID BLANCHARD

Print/Type Name

3095415-001

Signature

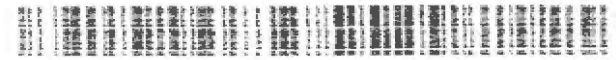
Date



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Customer No. 3093416-051

Route No. 435-8



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

- Copy 1 – GENERATOR COPY: Sent by Destination Facility to Generator (White)
- Copy 2 – DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
- Copy 3 – TRANSPORTER COPY: Retained by Transporter (Yellow)
- Copy 4 – TRANSFER STATION COPY: Retained by Transfer Station (Pink)
- Copy 5 – GENERATOR COPY – Retained by Generator (Gold)

- 1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
- 2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

HECTOR BARRIENTOS *[Signature]* **4/16/2020**
Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler
(Name and Address)

DESTROYED

APR 23 2020

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

CURTIS BAY ENERGY
BALTIMORE, MD 21226
Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)
 Received in accordance with items 11, 12 & 13

[Signature] *[Signature]* **42220**
Print/Type Name Signature Date
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

#8 **Curtis Bay Energy**
3200 Hawkins Point Road
Baltimore, MD 21226
#9 **Phone # (410) 354-3228**
#10 **Permit # 2011-WMI-0036**

TRANSPORTER

DESTINATION

1. Generator's Name and Mailing Address

ATTN: RINSE CHECKS, INC
RINSE HEALTHCARE
66 SEMIWAY BLVD
FORT WASHINGTON, NY 119504618

2. Tracking Form Number

ME11095823

4. State Permit or ID No.

6. Telephone Number

8006993275

7. State Transporter or ID No(s).

IL-033

3. Telephone Number

(916) 625-3799

5. Transporter's Name and Mailing Address

SPERIDYCLE, INC
23161 North Meach Drive
Lake Forest, Illinois 60045

9. Telephone Number

866-726-7422

10. State Permit or ID No.

0276060834

8. Destination Facility Name and Address

SPERIDYCLE, INC
1901 Pine Avenue
Warren, OH 44430

11. USDOT Shipping Name (or waste description)

HM		11a. Container Type	12. Total No. Containers	13. Total Volume		
a.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated)	Corrugated Box	5	21	CF
b.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated)	Reusable Tub			CF
c.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated)	Wheeled Rack			CF
d.		Regulated Medical Waste (Treated)				CF

14. Special Handling Instructions and Additional Information

10 WW45 = 5 *10* WW45 = 5

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

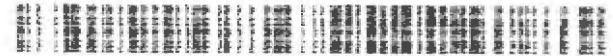
Jeremy Elkens *[Signature]* **4/16/2020**
Print/Type Name Signature Date



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Customer No: 3098415-001

Route No: 435- 2



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

1. Generator's Name and Mailing Address
ATWEN: RINSE CHACHEL, LEW
EXWAGE HEALTHCARE
80 BEAVIEW BLVD
FORT WASHINGTON, NY 116504618

2. Tracking Form Number
MDL100875X

4. State Permit or ID No.

3. Telephone Number (315) 737-2739

5. Transporter's Name and Mailing Address
BBERICYCLE, INC
23181 North Keith Drive
Lake Forest, Illinois 60045

6. Telephone Number
800-632-2278

7. State Transporter or ID No(s).
IL-033

8. Destination Facility Name and Address
BBERICYCLE, INC
1931 Pine Avenue
WARREN, OH 44482

9. Telephone Number
330-271-7911

10. State Permit or ID No.
0330190004

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM
Copy 1 – GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 – DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 – TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 – TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 – GENERATOR COPY – Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)
HECTOR BARRIENTOS *[Signature]*
Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)
18. Telephone Number
19. State Transporter or ID No(s).

TRANSPORTER

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)
 Received in accordance with items 11, 12 & 13
crack cfl *[Signature]* 41520
Print/Type Name Signature Date
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)
#9
#10

11. USDOT Shipping Name (or waste description)		11a. Container Type	12. Total No. Containers	13. Total Volume	
HM					
a.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated)	Corrugated Box	4	16.8	CF
b.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated)	Reusable Tub			CF
c.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated)	Wheeled Rack			CF
d.	Regulated Medical Waste (Treated)				CF

14. Special Handling Instructions and Additional Information
APR 17 2020
P/O CURTIS BAY ENERGY
BALTIMORE, MD 21226
WY45-5
10 WW45=5

15. Generator's Certification
I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labeled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.
DAVID BLANCHARD *[Signature]*
Print/Type Name Signature Date



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Cost 948 (2) 988418-00

Route 1/01 495



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

1. Generator's Name and Mailing Address

ATTN: RINGI CHACKO, MPH
FOX/GE HEALTHCARE
90 SLAVEN BLVD
FORT WASHINGTON, NY 119504618

2. Tracking Form Number

NEL100578F

4. State Permit or ID No.

3. Telephone Number

516-732-2795

5. Transporter's Name and Mailing Address

SPHICYCLE, INC
2864 North Knick Drive
Lake Forest, Illinois 60048

6. Telephone Number

815-636-0776

7. State Transporter or ID No(s).

IL-033

8. Destination Facility Name and Address

1901 Pine Avenue
MARBEN, IL 60448

9. Telephone Number

815-755-7825

10. State Permit or ID No.

0273050834

11. USDOT Shipping Name (or waste description)

HM

11a. Container Type

12. Total No. Containers

13. Total Volume

- | | | | | | | |
|----|---|---|----------------|---|------|----|
| a. | X | UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated) | Corrugated Box | 6 | 25.2 | CF |
| b. | X | UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated) | Reusable Tub | | | CF |
| c. | X | UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated) | Wheeled Rack | | | CF |
| d. | | Regulated Medical Waste (Treated) | | | | CF |

14. Special Handling Instructions and Additional Information

70 WY45 = 6 70 WW45 = 10

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

Jeffery Ekins
Print/Type Name 8886416-901

[Signature]
Signature Date

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

- Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
- Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
- Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
- Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
- Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

- A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
- Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

HECTOR BARRIENTOS [Signature]
Print/Type Name Signature Date

TRANSPORTER

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)
 Received in accordance with items 11, 12 & 13

[Signature] [Signature] 9820
Print/Type Name Signature Date

23. Destination Facility (An address change should be noted by item number and initials)

DESTROYED
APR 09 2020
CURTIS BAY ENERGY
BALTIMORE, MD 21226



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Cost: \$10.00 (800) 456-6001

Route No. 405-2



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

1. Generator's Name and Mailing Address

ATTN: KINSEY CHACKO, J.P.H.
FBI/WGE HEALTHCARE
60 SEAVIEW BLVD
FORT WASHINGTON, NY 11050-6618

2. Tracking Form Number

MDL100563V

4. State Permit or ID No.

3. Telephone Number

(516) 626-3109

5. Transporter's Name and Mailing Address

STERICYCLE, INC
23161 Marsh Knick Drive
Lake Forest, Illinois 60045

6. Telephone Number

81562399275

7. State Transporter or ID No(s).

IL-033

8. Destination Facility Name and Address

STERICYCLE INC
1901 Pine Avenue
WARRER, OH 44080

9. Telephone Number

360-731-7422

10. State Permit or ID No.

0203010504

11. USDOT Shipping Name (or waste description)

HM

11a. Container Type

12. Total No. Containers

13. Total Volume

a.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	6 25-2 CF
b.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub	CF
c.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack	CF
d.		Regulated Medical Waste (Treated)		CF

14. Special Handling Instructions and Additional Information

APR 11 2020

CURTIS BAY ENERGY
PO WY45 BALTIMORE, MD 21226 WW45-5

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

3/26/2020

JEREMY ELKINS
Print/Type Name Signature Date

8098418-001

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

HECTOR BARRIENTES
Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)

Received in accordance with items 11, 12 & 13

CS SAO 4/11/20
Print/Type Name Signature Date
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

#8 Curtis Bay Energy
3200 Hawkins Point Road
Baltimore, MD 21226
#9 Phone # (410) 354-3228
#10 Permit # 2011-WMI-0036

DESTINATION



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

GENERATOR

1. Generator's Name and Mailing Address		2. Tracking Form Number	
3. Telephone Number		4. State Permit or ID No.	
5. Transporter's Name and Mailing Address		6. Telephone Number	
8. Destination Facility Name and Address		9. Telephone Number	
11. USDOT Shipping Name (or waste description)		11a. Container Type	12. Total No. Containers
13. Total Volume			
a.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	
b.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub	2 8
c.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack	
d.	Regulated Medical Waste (Treated)		

INSTRUCTIONS

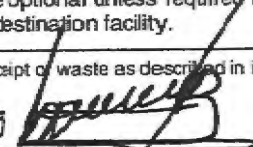
INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
 Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
 Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
 Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
 Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
 2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

TRANSPORTER

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

HECTOR BORRIENTOS 

Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

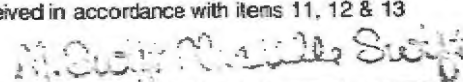
Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)

Received in accordance with items 11, 12 & 13

 **3/23/20**

Print/Type Name Signature Date

(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

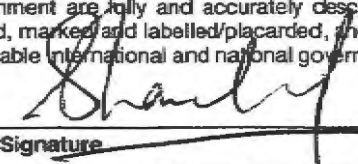
23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

14. Special Handling Instructions and Additional Information

70 TBOI=2 % TBOI=2

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

DAVID BURKHARD 

Print/Type Name Signature Date



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

- Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
- Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
- Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
- Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
- Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

- 1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
- 2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

HECTOR BARRIENTOS *[Signature]*
Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)

Received in accordance with items 11, 12 & 13
A. Sack *[Signature]* **3/25/20**
Print/Type Name Signature Date
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

#9
#10

DESTINATION

TRANSPORTER

1. Generator's Name and Mailing Address		2. Tracking Form Number																									
3. Telephone Number		4. State Permit or ID No.																									
5. Transporter's Name and Mailing Address		6. Telephone Number																									
8. Destination Facility Name and Address		7. State Transporter or ID No(s).																									
		IL-033																									
		9. Telephone Number																									
		10. State Permit or ID No.																									
11. USDOT Shipping Name (or waste description)	11a. Container Type	12. Total No. Containers	13. Total Volume																								
<table border="1"> <tr> <td>HM</td> <td></td> <td></td> <td></td> </tr> <tr> <td>a.</td> <td>X</td> <td>UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)</td> <td>Corrugated Box</td> </tr> <tr> <td>b.</td> <td>X</td> <td>UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)</td> <td>Reusable Tub</td> </tr> <tr> <td colspan="4" style="text-align: center;">DESTROYED</td> </tr> <tr> <td>c.</td> <td></td> <td>UN3294, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)</td> <td>Wheeled Rack</td> </tr> <tr> <td>d.</td> <td></td> <td>Regulated Medical Waste (Treated)</td> <td></td> </tr> </table>	HM				a.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	b.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub	DESTROYED				c.		UN3294, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack	d.		Regulated Medical Waste (Treated)			12	5004 CF
HM																											
a.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box																								
b.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub																								
DESTROYED																											
c.		UN3294, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack																								
d.		Regulated Medical Waste (Treated)																									

14. Special Handling Instructions and Additional Information

MAR 27 2020

CURTIS BAY ENERGY
BALTIMORE, MD 21226
PU WW445 = 12 **10 WW445 = 15**

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

DAVID BRANCHARD *[Signature]*
Print/Type Name Signature Date



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

GENERATOR

1. Generator's Name and Mailing Address		2. Tracking Form Number		
3. Telephone Number		4. State Permit or ID No.		
5. Transporter's Name and Mailing Address		6. Telephone Number		
8. Destination Facility Name and Address		9. Telephone Number		
11. USDOT Shipping Name (or waste description)		11a. Container Type	12. Total No. Containers	13. Total Volume
HM				
a.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated)	Corrugated Box	12	50.4 CF
b.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated)	Reusable Tub		CF
c.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated)	Wheeled Rack		CF
d.	Regulated Medical Waste (Treated)			CF

INSTRUCTIONS

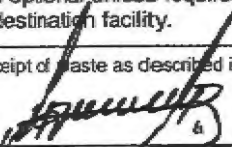
INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
 Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
 Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
 Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
 Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
 2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

TRANSPORTER

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

HECTOR BARRIENTOS  &
 Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)


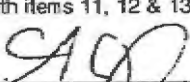
Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)

Received in accordance with items 11, 12 & 13

  3/18/20
 Print/Type Name Signature Date
 (If other than the destination facility, indicate address, phone and permit or ID number - box 14)

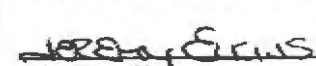

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

14. Special Handling Instructions and Additional Information

PU W445 = 12 90 W445 = 15

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

 
 Print/Type Name Signature Date

DESTROYED

MAR 25 2020
 CURTIS BAY ENERGY
 BALTIMORE, MD 21226



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

REGULATED MEDICAL WASTE TRACKING FORM

GENERATOR

1. Generator's Name and Mailing Address		2. Tracking Form Number	
3. Telephone Number		4. State Permit or ID No.	
5. Transporter's Name and Mailing Address		6. Telephone Number	
8. Destination Facility Name and Address		9. Telephone Number	
11. USDOT Shipping Name (or waste description)		11a. Container Type	12. Total No. Containers
HM			
a.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	8
b.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub	33-6
c.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack	
d.	Regulated Medical Waste (Residual)		

14. Special Handling Instructions and Additional Information

MAR 17 2020
P/W 445-8
CORTIS BAY ENERGY
BALTIMORE, MD 21226
WY45=10

15. Generator's Certification
I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

VICTOR RIQUELME
Print/Type Name Signature Date

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

TRANSPORTER

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

HECTOR BARRIENTOS
Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)

Received in accordance with items 11, 12 & 13

M Grossman
Print/Type Name Signature Date 3/12/20

(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

#8 Curtis Bay Energy
3200 Hawkins Point Road
Baltimore, MD 21226
Phone # (410) 354-3228
Permit # 2011-WMI-0036

#9
#10



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Emergency Response Number: CHEMTREC Customer No. 21 132 1-800-424-9300

REGULATED MEDICAL WASTE TRACKING FORM

GENERATOR

1. Generator's Name and Mailing Address		2. Tracking Form Number	
3. Telephone Number		4. State Permit or ID No.	
5. Transporter's Name and Mailing Address		6. Telephone Number	
8. Destination Facility Name and Address		7. State Transporter or ID No(s). IL-033	
11. USDOT Shipping Name (or waste description)		11a. Container Type	12. Total No. Containers
13. Total Volume			
a.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	CF
b.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub	CF
c.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack	CF
d.	Regulated Medical Waste (Treated)		CF

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
 Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
 Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
 Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
 Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
 2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

TRANSPORTER

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

HECTOR BORRIENTOS *[Signature]*
 Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)

Received in accordance with items 11, 12 & 13

Print/Type Name Signature Date
 (If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

14. Special Handling Instructions and Additional Information

1/0 W445 = 1/0 W445 = (NO WASTE)

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

VICTOR RIQUELME *[Signature]*
 Print/Type Name Signature Date



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

1. Generator's Name and Mailing Address
ATTN: RINSI CHACKO, .PH
RXW/GE HEALTHCARE
80 SEAVIEW BLVD
PORT WASHINGTON, NY 110504618

2. Tracking Form Number
MDLI0054GZ

4. State Permit or ID No.

3. Telephone Number (516) 626-2799

5. Transporter's Name and Mailing Address
STERICYCLE, INC
28161 North Keith Drive
Lake Forest, Illinois 60045

6. Telephone Number
8006339278

7. State Transporter or ID No(s)
IL-033

8. Destination Facility Name and Address
STERICYCLE INC,
1901 Pine Avenue
WARREN, OH 44483

9. Telephone Number
866-783-7422

10. State Permit or ID No.
0278080634

11. USDOT Shipping Name (or waste description)	11a. Container Type	12. Total No. Containers	13. Total Volume
HM			
a. X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	1	4.2 CF
b. X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub		CF
c. X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack		CF
d. Regulated Medical Waste(Treated)			CF

14. Special Handling Instructions Additional Information
DESTROYED
Incineration
Dlu MAR 07 2020

15. Generator's Signature
I hereby certify that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.
Print/Type Name: David Buren Signature: [Signature] Date: 2/20/2020

INSTRUCTIONS
INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM
Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 - GENERATOR COPY - Retained by Generator (Gold)
1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)
Ramon Maffeo Ramon Maffeo 2/20/2020
Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)
18. Telephone Number
19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)
[Signature] [Signature] [Date]
Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)
 Received in accordance with items 11, 12 & 13
[Signature] [Signature] 2/27/20
Print/Type Name Signature Date
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)
RCAD

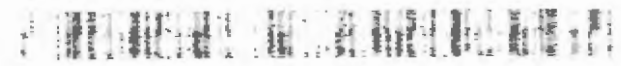
GENERATOR

TRANSPORTER

DESTINATION



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

GENERATOR

1. Generator's Name and Mailing Address CITY OF NEW YORK 100 WALL STREET NEW YORK, NY 10038-4201		2. Tracking Form Number 100384201	
3. Telephone Number		4. State Permit or ID No.	
5. Transporter's Name and Mailing Address LIFEPOINT LLC 14001 Middle Road Greensboro, NC 27409-4013		6. Telephone Number 757-834-2773	
8. Destination Facility Name and Address CITY OF NEW YORK 100 WALL STREET NEW YORK, NY 10038-4201		7. State Transporter or ID No(s) IL-033	
11. USDOT Shipping Name (or waste description) HM		11a. Container Type	13. Total Volume
a. <input checked="" type="checkbox"/>	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	1 4.2 CF
b. <input checked="" type="checkbox"/>	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub	CF
c. <input checked="" type="checkbox"/>	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack	CF
d. <input type="checkbox"/>	Regulated Medical Waste (Treated)		CF

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

TRANSPORTER

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)
HECTOR BARRIENTOS *[Signature]* 2/13/20
Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)
 Received in accordance with items 11, 12 & 13
CJ ANON 2/10/20
Print/Type Name Signature Date
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

#8
#9
#10

14. Special Handling Instructions and Additional Information
DESTROYED
FEB 23 2020
% WV45 = 1 % WV45 = 1
CITY OF NEW YORK
100 WALL STREET
NEW YORK, NY 10038-4201

15. Generator's Certification
I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport, according to applicable international and national government regulations.

Victor Riquelme *[Signature]*
Print/Type Name Signature Date



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

GENERATOR

1. Generator's Name and Mailing Address CORTIS BAY ENERGY, INC. 30075 WY 43 BALTIMORE, MD 21226		2. Tracking Form Number 2011-0033	
3. Telephone Number 410-326-7000		4. State Permit or ID No.	
5. Transporter's Name and Mailing Address STEPHENSON, INC. 28131 North Zephyr Square Jude Square, Columbia, SC 29204		6. Telephone Number 803-733-1100	
8. Destination Facility Name and Address CORTIS BAY ENERGY, INC. 30075 WY 43 BALTIMORE, MD 21226		7. State Transporter or ID No(s). IL-033	
9. Telephone Number 410-326-7000		10. State Permit or ID No. 2011-0033	
11. USDOT Shipping Name (or waste description)	11a. Container Type	12. Total No. Containers	13. Total Volume
HM			
a. X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	3	12.6 CF
b. X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub		CF
c. X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack		CF
d. Regulated Medical Waste (Treated)			CF

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

TRANSPORTER

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)
HECTOR BARRIENTOS *[Signature]* **2/17/20**
Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)
 Received in accordance with items 11, 12 & 13
Check *[Signature]* **2/14/20**
Print/Type Name Signature Date
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

#8 **Curtis Bay Energy**
3200 Hawkins Point Road
Baltimore, MD 21226
#9 **Phone # (410) 354-3228**
#10 **Permit # 2011-WMI-0036**

14. Special Handling Instructions and Additional Information
FEB 17 2020

DESTROYED

WY 43

15. Generator's Certification
I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

VICTOR RIQUELME *[Signature]* **2/17/20**
Print/Type Name Signature Date



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Emergency Response Number: CHEMTREC Customer No. 21 132 1-800-424-9300

REGULATED MEDICAL WASTE TRACKING FORM

GENERATOR

1. Generator's Name and Mailing Address		2. Tracking Form Number	
3. Telephone Number		4. State Permit or ID No.	
5. Transporter's Name and Mailing Address		6. Telephone Number	
8. Destination Facility Name and Address		9. Telephone Number	
11. USDOT Shipping Name (or waste description)		11a. Container Type	12. Total No. Containers
13. Total Volume			

DESTROYED

FEB 12 2020

**CURTIS BAY ENERGY
BALTIMORE, MD 21226**

14. Special Handling Instructions and Additional Information

P-6 WY4.S
P-6 WY4.S

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labeled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

Melanie S. Piaz...
Print/Type Name Signature Date

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

TRANSPORTER

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)

Received in accordance with items 11, 12 & 13

Print/Type Name Signature Date

(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

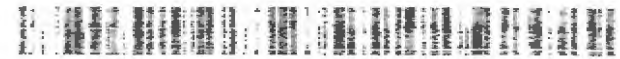
CURTIS BAY ENERGY
3200 HAWKINS POINT ROAD
BALTIMORE MD 21226
PH#410-354-3228
PERMIT#2011-WMI-0036



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Form DS-1000-010

Rev. 10/10



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

1. Generator's Name and Mailing Address
RITON HEALTHCARE
RITON HEALTHCARE
611 BRADLEY BLVD
RITON CONNECTICUT 06250

2. Tracking Form Number
0000000000

4. State Permit or ID No.

3. Telephone Number (860) 825-0793

5. Transporter's Name and Mailing Address
STERIS CORP
29160 Ironwood Circle
Lake Forest, Illinois 60149

6. Telephone Number
815-336-2000

7. State Transporter or ID No(s).
IL-033

8. Destination Facility Name and Address
STERIS CORP
1511 South State
CANTON, OH 44705

9. Telephone Number
330-350-7600

10. State Permit or ID No.
107-100-0000

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM
Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

TRANSPORTER

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)
HECTOR BARRIENTOS *[Signature]*
Print/Type Name Signature Date
17. Transporter 2 or Intermediate Handler (Name and Address)
18. Telephone Number
19. State Transporter or ID No(s).

DESTINATION

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)
DESTROYED
Print/Type Name Signature Date
21. New Tracking Form Number (for consolidated or remanifested waste)
CURTIS BAY ENERGY
BALTIMORE, MD 21226
22. Destination Facility (Certification of receipt of waste as described in items 1, 12 & 13)
 Received in accordance with items 11, 12 & 13
BW BWL *[Signature]* 1/29/20
Print/Type Name Signature Date
23. Discrepancy Box (Any discrepancies should be noted by item number and initials)
#8 **Curtis Bay Energy**
3200 Hawkins Point Road
Baltimore, MD 21226
#9 **Phone # (410) 354-3228**
#10 **Permit # 2011-WMI-0036**

GENERATOR

11. USDOT Shipping Name (or waste description)		11a. Container Type	12. Total No. Containers	13. Total Volume	
HM					
a.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	8	33.6	CF
b.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub			CF
c.	X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack			CF
d.	Regulated Medical Waste (Treated)				CF

14. Special Handling Instructions and Additional Information
P/O WY45 = 8 P/O WW45 = 10

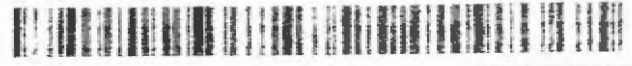
15. Generator's Certification
I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labelled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.
VICTOR RIVARDE *[Signature]* 1/29/20
Print/Type Name Signature Date



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

2025-01-07 09:54:43

Route No. 835 10



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

GENERATOR

1. Generator's Name and Mailing Address		2. Tracking Form Number	
3. Telephone Number		4. State Permit or ID No.	
5. Transporter's Name and Mailing Address		6. Telephone Number	
8. Destination Facility Name and Address		7. State Transporter or ID No(s) IL-033	
9. Telephone Number		10. State Permit or ID No.	
11. USDOT Shipping Name (or waste description)	11a. Container Type	12. Total No. Containers	13. Total Volume
HM			
a. <input checked="" type="checkbox"/> UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	6	25.2 (CF)
b. <input checked="" type="checkbox"/> UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub		CF
c. <input checked="" type="checkbox"/> UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack		CF
d. <input type="checkbox"/> Regulated Medical Waste (Treated)			CF

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

Copy 1 – GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 – DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 – TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 – TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 – GENERATOR COPY – Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

TRANSPORTER

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

Jean-Claude...
Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s)

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)

Received in accordance with items 11, 12 & 13

Delet Druet 1/25/20
Print/Type Name Signature Date

(If other than the destination facility, indicate address, phone, and permit ID no. in box 23)

23. Discrepancy Box (Any discrepancies should be noted in this box with amount and initials)

14. Special Handling Instructions and Additional Information

DESTROYED
JAN 31 2020
Curtis Bay Energy
BALTIMORE MD 21226
DO
UNWYS = 10

15. Generator's Certification

I hereby certify that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labeled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

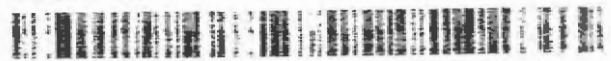
W. Davis S. P. 1/25/20
Print/Type Name Signature Date

CURTIS BAY ENERGY
3200 HAWKINS POINT ROAD
BALTIMORE MD 21226
PH#410-354-3228
PERMIT#2011-WM-0036



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Order Form - 03-6478-01 Revision 108-08



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

GENERATOR

1. Generator's Name and Mailing Address AT&T Bldg. 2000 Rm 303 HealthCare 20 Beaver Blvd Port Washington NY 11050-9613		2. Tracking Form Number 0000000000	
3. Telephone Number 718-224-0100		4. State Permit or ID No.	

5. Transporter's Name and Mailing Address WINDTUNNEL, INC 27150 Maple Terrace Drive Lake Forest, IL 60045		6. Telephone Number 630-439-2775	
		7. State Transporter or ID No(s). IL-033	

8. Destination Facility Name and Address Curtis Bay Energy 3200 Hawkins Point Road Baltimore, MD 21226		9. Telephone Number 410-334-3228	
		10. State Permit or ID No. 2010000000	

11. USDOT Shipping Name (or waste description)	11a. Container Type	12. Total No. Containers	13. Total Volume
HM			
a. X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Corrugated Box	17	46-2
b. X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Reusable Tub		CF
c. X UN3291, Regulated Medical Waste, n.o.s., 6.2, PGII (Untreated)	Wheeled Rack		CF
d. Regulated Medical Waste (Treated)			CF

14. Special Handling Instructions and Additional Information
DESTROYED
JAN 22 2020
Curtis Bay Energy
W0445-11
W0445-7

15. Generator's Certification
I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labeled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

VICTOR RIQUELME
Signature: *[Signature]* Date: _____

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

1. A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 23 must be completed by the destination facility.

TRANSPORTER

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

[Signature]
Print/Type Name: _____ Signature: _____ Date: _____

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name: _____ Signature: _____ Date: _____

21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)
 Received in accordance with items 11, 12 & 13

[Signature]
Print/Type Name: _____ Signature: _____ Date: 1/20/20
(If other than the destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

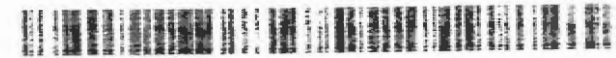
#8 Curtis Bay Energy
3200 Hawkins Point Road
Baltimore, MD 21226
#9 Phone # (410) 334-3228
#10 Permit # 2011-W044-0036



New York State Department of Environmental Conservation
Division of Solid & Hazardous Materials

Class E 60914/3-07

Route to 485-7



REGULATED MEDICAL WASTE TRACKING FORM

Emergency Response Number: CHEMTREC Customer No. 21132 1-800-424-9300

1. Generator's Name and Mailing Address

ATTN: RYAN CRONO, JR.
KAWGE HEALTHCARE
90 BRAVIEW BLVD
FORT WASHINGTON, NY 119504619

2. Tracking Form Number

MDLIC0919A

4. State Permit or ID No.

IL-033

3. Telephone Number

(516) 628-1739

5. Transporter's Name and Mailing Address

STERECYCLE INC
22161 North Walsh Drive
Lake Forest, Illinois 60146

6. Telephone Number

800 55 89872

7. State Transporter or ID No(s).

IL-033

8. Destination Facility Name and Address

STERECYCLE INC
1901 Pine Avenue
GARY, IN 46438

9. Telephone Number

317 338 1559

10. State Permit or ID No.

IN 033 0559

11. USDOT Shipping Name (or waste description)

HM

11a. Container Type

12. Total No. Containers

13. Total Volume

a.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated)	Corrugated Box	3	12.8 CF
b.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated)	Reusable Tub		CF
c.	X	UN3291, Regulated Medical Waste, n.o.s., 6.2, PGI (Untreated)	Wheeled Rack		CF
d.		Regulated Medical Waste (Treated)			CF

14. Special Handling Instructions and Additional Information

Pl4 WY45-3
Olo WW45-8

15. Generator's Certification

I hereby declare that the contents of this consignment are fully and accurately described above by the proper shipping name and are classified, packaged, marked and labeled/placarded, and are in all respects in proper condition for transport according to applicable international and national government regulations.

Medanis S. Diaz IV
Print/Type Name: 5098418-001
Signature: [Signature]
Date: 12/10/20

INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING REGULATED MEDICAL WASTE TRACKING FORM

- Copy 1 - GENERATOR COPY: Sent by Destination Facility to Generator (White)
- Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility (Green)
- Copy 3 - TRANSPORTER COPY: Retained by Transporter (Yellow)
- Copy 4 - TRANSFER STATION COPY: Retained by Transfer Station (Pink)
- Copy 5 - GENERATOR COPY - Retained by Generator (Gold)

- A copy of this shipping document must accompany each shipment of regulated medical waste generated in New York or another covered State.
- Items numbered 1-14 must be completed before the generator can sign the certification. Items 4, 10 and 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

TRANSPORTER

16. Transporter 1 (Certification of receipt of waste as described in items 11, 12 & 13)

Richard Harris
Print/Type Name: [Signature]
Date: 1-7-20

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter or ID No(s).

20. Transporter 2 or Intermediate Handler (Certification of receipt of waste as described in items 11, 12 & 13)

Print/Type Name: [Signature]
Date:

21. New Tracking Form Number (for consolidated or remanifested waste)

22. Destination Facility (Certification of receipt of waste as described in items 11, 12 & 13)

Received in accordance with items 11, 12 & 13

Print/Type Name: [Signature]
Date: 1-7-20

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)

JAN 10 2020
Curtis Bay Energy
3200 Hawkins Point Road
Baltimore, MD 21226
Phone # (410) 354-3228
Permit # 2011-WMI-0036

DESTROYED

GENERATOR

DESTINATION