NEW YORK STATE OF OPPORTUNITY | Department of Environmental Conservation

REGULATED MEDICAL WASTE FACILITY ANNUAL REPORT

This Regulated Medical Waste Facility Annual Report is for the year of operation from January 01, 2021 to December 31, 2021

SECTION 1 – GENERAL INFORMATION

FACILITY INFORMATION

FACILITY NAME: Faxton St. Lukes Healthcare			
FACILITY LOCATION ADDRESS: 1656 Champlin Ave	**FACILITY CITY:** New Hartford	**STATE:** NY	**ZIP CODE:** 13413
FACILITY TOWN: New Hartford	**FACILITY COUNTY:** Oneida	**FACILITY PHONE NUMBER:** 315-624-6240	
FACILITY NYS PLANNING UNIT: (A list of NYS Planning Units can be found at the end of this report). Oneida-Herkimer Solid Waste Authority		**NYSDEC REGION #:** R-6	

360 PERMIT #: 6-3048-00127/02001	**DATE ISSUED:** 10/9/2014	**DATE EXPIRES:** 9/30/2024	**NYS DEC ACTIVITY CODE OR REGISTRATION NUMBER:** 33H01

FACILITY CONTACT: Allen Hurd	☒ public ☐ private	**CONTACT PHONE NUMBER:** 315-624-6240	**CONTACT FAX NUMBER:** 315-624-6943
CONTACT EMAIL ADDRESS: ahurd@mvhealthsystem.org			

OWNER INFORMATION

OWNER NAME: Faxton-St. Lukes Healthcare	**OWNER PHONE NUMBER:** 315-624-6240	**OWNER FAX NUMBER:** 315-624-6943	
OWNER ADDRESS: 1656 Champlin Ave	**OWNER CITY:** New Hartford	**STATE:** NY	**ZIP CODE:** 13413
OWNER CONTACT: Allen Hurd	**OWNER CONTACT EMAIL ADDRESS:** ahurd@mvhealthsystem.org		

OPERATOR INFORMATION

OPERATOR NAME: ☑ same as owner ☒ public ☐ private

PREFERENCES

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

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

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

Did you operate in 2021? ☒ 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)	166.6						Oneide-Herkimer Solid W
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							

SECTION 3 – DISPOSAL DESTINATION

WASTE TYPE	AMOUNT (tons)	FACILITY NAME AND ADDRESS	STATE	COUNTY	NYS PLANNING UNIT (See Attached List of NYS Planning Units)
Treated Waste	166.6	Oneida Herkimer Soild Waste Authority	NY	Oneida	Oneide-Herkimer Solid Waste Authority (OHSW/
TOTAL WASTE	166.6				

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 Solid Waste Management
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	Date
	1/20/22

Name (Print or Type)	Title (Print or Type)
Allen Hurd	Manager

Email (Print or Type): ahurd@mvhealthsystem.org

Address	City
1656 Champlin ave	New Hartford

State and Zip	Phone Number
NY 13413	(315) 6240-6240

ATTACHMENTS: ☐ YES ☐

NO Reprinted (12/21)