

REGULATED MEDICAL WASTE FACILITY ANNUAL REPORT

This Regulated Medical Waste Facility Annual Report is for the year of operation from <u>January 01, 2022</u> to <u>December 31, 2022</u>

SECTION 1 – GENERAL INFORMATION

FACILITY INFORMATION						
FACILITY NAME:						
FACILITY LOCATION ADDRESS:		FACILITY	FACILITY CITY:		STATE	ZIP CODE:
FACILITY TOWN:		FACILITY COUNTY:		FACILITY PHONE NUMBER:		ONE NUMBER:
FACILITY NYS PLANNING UNIT: (A list of NYS Planning Units can be found at the end of this report). NYSDEC REGION #:						_
360 PERMIT #:	DATE IS	SSUED:	DATE EXPIRES:	S: NYS DEC ACTIVITY CODE OR REGISTRATION NUMBER:		
FACILITY CONTACT:		□ public CONTACT PHONE CONTACT FAX NU private NUMBER:		T FAX NUMBER:		
CONTACT EMAIL ADDRESS:						
7-			NFORMATION			
OWNER NAME:		OWNER F	PHONE NUMBER:	OWN	ER FAX	NUMBER:
OWNER ADDRESS:		OWNER			STATE	ZIP CODE:
OWNER CONTACT:		OWNER	CONTACT EMAIL ADDF	RESS:		
		OPERATOR	RINFORMATION			
OPERATOR NAME: sa	me as owne				□publio □privat	
Droformed address to receive com	oo nondon		ERENCES			
Preferred address to receive corr Other (provide):	esponaen	ICE: 🔲 Facili	ty location address		Owner	address
Preferred email address:	ility Contac	t 🗆] Owner Contact			
Preferred individual to receive correspondence:						
Did you operate in 2022? ☐ Yes; Complete this form. ☐ No; Complete and submit Sections 1 and 9. 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:					

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)						Stericycle, 31 Lower River Street, Oneonta, NY 13820	
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					
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

SEC	TION 5 - COST ESTIMATES AND FINANCIAL ASSURANCE DOCUMENTS
Are there requ	ired cost estimates and financial assurance documents for closure?
□ Yes □ N	lo If yes, attach additional sheets reflecting annual adjustments for inflation and any changes to the Closure Plan?
	SECTION 6 - PROBLEMS
Were any proi	olems encountered during the reporting period (e.g., specific occurrences which have led to changes edures)?
□Yes □ N	lo If yes, attach additional sheets identifying each problem and the methods for resolution of the problem.
	SECTION 7 - CHANGES
Were there ar	y changes from approved reports, plans, specifications, and permit conditions?
□Yes □ N	lo If yes, attach additional sheets identifying changes with a justification for each change.
s	ECTION 8 - PERMIT/CONSENT ORDER REPORTING REQUIREMENTS
Are there any form?	additional permit/consent order reporting requirements not covered by the previous sections of this
☐ Yes ☐ N	lo 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.

and 2	1/19/2023
Signature	Date
Name (Print or Type)	Title (Print or Type)
Email (P	rint or Type)
Address	City
State and Zip	305 1506 () Phone Number
Otate and Zip	i none number

ATTACHMENTS: ____ YES

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, 2023.

Reporting of the information indicated on this Regulated Medical Waste Annual Report form is required pursuant to 6 NYCRR 360.19(k) and 365-2.8. 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.

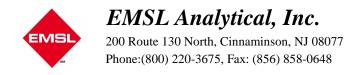
SECTION 9: Sign and date the form and follow the instructions provided for submission of form.

2022 Annual Report Addendum

The Columbia University BSL-3 labs registration was approved by the NYS-DEC on November 17th, 2020. This report is an assurance that our BSL-3 RMW management SOP is being followed, which requires third party verification of biological indicators. Please find below the biological indicators third party verification reports.

Biological Indicator Third Party Lab Verification Log 2022

Report number	Date reported	Reason	Center	Facility	Weight generated (lbs)
372212487	8/16/2022	Acquisition of new batch of biological indicators	ICM	1130 St Nicholas Ave., 10th floor, New York, NY 10032	571
372213712	8/31/2022	Reached 200 hours of operation	ADARC	701 West 168th St., 11th floor, New York, NY 10032	1780
N/A	N/A	No new batch or reached 200 hours of operation	CII	722 W 168th St., 19th floor, New York, NY 10032	270



Client: Columbia University
630 West 168th St
New York, NY 10032

Attn. Samira Joussef-Pina

EMSL Order ID: 372212487

Date Received: 8/9/2022

Date Analyzed: 8/11/2022

Date Reported: 8/16/2022

Project: Autoclave Biological Indicators

Verification Testing for Commercially Purchased Biological Indicators Indicator Organism: Geobacillus Stearothermophilus

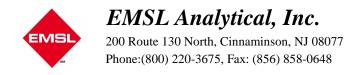
Lab Sample Number	Client Sample ID & Location	Sampling Date & Time	Result (Present/Absent)
372212487-0001	1 - Autoclaved	8/8/22 12:00 PM	Absent
372212487-0002	2 - Autoclaved	8/8/22 12:00 PM	Absent
372212487-0003	3 - Autoclaved	8/8/22 12:00 PM	Absent
372212487-0004	4 - Control Non-Autoclaved	8/8/22 12:00 PM	Present

NA = Not applicable

Vincent Iuzzolino, M.S. Microbiology Laboratory Director

or other approved signatory

EMSL maintains liability limited to cost of analysis. Interpretation and use of test results are the responsibility of the client. This report relates only to the samples reported above, and may not be reproduced, except in full, without written approval by EMSL. EMSL bears no responsibility for sample collection activities or analytical method limitations. The report reflects the samples as received. When the information supplied by the customer can affect the validity of the results, it will be noted on the report.



Client: Columbia University
630 West 168th St
New York, NY 10032

Attn. Samira Joussef-Pina

EMSL Order ID: 372213712

Date Received: 8/26/2022

Date Analyzed: 8/29/2022

Date Reported: 8/31/2022

Project: Autoclave Biological Indicators

Verification Testing for Commercially Purchased Biological Indicators Indicator Organism: Geobacillus Stearothermophilus

Lab Sample Number	Client Sample ID & Location	Sampling Date & Time	Result (Present/Absent)
272212712 0001	1 N A . 1 10 . 1	0/02/02 < 00 PM	D
372213712-0001	1 - Non-Autoclaved Control	8/23/22 6:00 PM	Present
372213712-0002	2 - Autoclaved	8/23/22 6:00 PM	Absent
372213712-0003 372213712-0004	3 - Autoclaved 4 - Autoclaved	8/23/22 6:00 PM 8/23/22 6:00 PM	Absent Absent

NA = Not applicable

Vincent Iuzzolino, M.S. Microbiology Laboratory Director

or other approved signatory

EMSL maintains liability limited to cost of analysis. Interpretation and use of test results are the responsibility of the client. This report relates only to the samples reported above, and may not be reproduced, except in full, without written approval by EMSL. EMSL bears no responsibility for sample collection activities or analytical method limitations. The report reflects the samples as received. When the information supplied by the customer can affect the validity of the results, it will be noted on the report.