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.

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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, 2022 to December 31, 2022

SECTION 1 – GENERAL INFORMATION

FACILITY INFORMATION

FACILITY NAME: Cardinal Health Nuclear & Precision Health Solutions #1034

FACILITY LOCATION ADDRESS:	FACILITY CITY:	STATE:	ZIP CODE:
7 Walker Way	Albany	NY	12205

FACILITY TOWN:	FACILITY COUNTY:	FACILITY PHONE NUMBER:
Town Of Colonie	Albany	518 862 0213

FACILITY NYS PLANNING UNIT: (A list of NYS Planning Units can be found at the end of this report). Capital Region Solid Waste Management Partnership (CRSWMP)

NYSDEC REGION #: 4

360 PERMIT #:	DATE ISSUED:	DATE EXPIRES:	NYS DEC ACTIVITY CODE OR REGISTRATION NUMBER:
Reg.#01J20101	8-28-2019	8-28-2024	175-4

FACILITY CONTACT:	☐ public ☒ private	CONTACT PHONE NUMBER:	CONTACT FAX NUMBER:
Patrick J Broderick RSO		518 862 0213	518 862 0223

CONTACT EMAIL ADDRESS: patrick.broderick@cardinalhealth.com

OWNER INFORMATION

OWNER NAME:	OWNER PHONE NUMBER:	OWNER FAX NUMBER:
Cardinal Health 414,LLC	614 757 5000	614 652 4598

OWNER ADDRESS:	OWNER CITY:	STATE:	ZIP CODE:
7000 Cardinal Place	Dublin	OH	46017

OWNER CONTACT:	OWNER CONTACT EMAIL ADDRESS:
Cardinal Health/Quality & Regulatory	healthphysics@cardinalhealth.com

OPERATOR INFORMATION

OPERATOR NAME: ☑ same as owner ☐ public ☒ private

PREFERENCES

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

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

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

Did you operate in 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: 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)							
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)	Very Short Lived 2.23554 Short Lived 0.02189	Very Short Lived 2.23554 Short Lived 0.02189				Stericycle Inc. 369 Park East Drive Woonsocket, RI 02895	
Pharmaceutical Waste							
Hazardous Waste							
Other (specify amount for each material including hydrolysate, ash, C&D, etc. requiring further processing.)							
TOTAL	2.25743						

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SECTION 3 – DISPOSAL DESTINATION

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

SECTION 4 – UNAUTHORIZED SOLID WASTE

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

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

Date Received	Type Received	Date Disposed	Disposal Method & Location

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.

Patrick Broderick — Signature

1/19/2023 — Date

Patrick Broderick — Name (Print or Type)

Radiation Safety Officer518 862 0213 — Title (Print or Type)

patrick.broderick@cardinalhealth.com — Email (Print or Type)

7 Walker Way — Address

Albany — City

New York 12205 — State and Zip

(518) 8620213 - 8620213 — Phone Number

ATTACHMENTS: ☐ YES ☐

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