Clear Forr

YEARLY REPORT

This Regulated Medical Waste Facility Annual Report is for the year of operation from Jan 1st through December 31,2022

SECTION 1 – FACILITY INFORMATION

FACILITY INFORMATION			
FACILITY NAME: PharmaLogic Albany			
FACILITY LOCATION ADDRESS: 14 Walker Way, Suite 5	**FACILITY CITY:** Albany	**STATE:** NY	**ZIP CODE:** 12205
FACILITY TOWN: Colonie	**FACILITY COUNTY:** Albany	**FACILITY PHONE NUMBER:** 518-713-2068	
FACILITY NYS PLANNING UNIT: (A list of NYS Planning Units can be found at the end of this report). **Colonie (Town)**		**NYSDEC REGION #:** 4	
360 PERMIT #: 4-0126-00642-0003	**DATE ISSUED:** 12/12/07	**DATE EXPIRES:**	**NYS DEC ACTIVITY CODE OR REGISTRATION NUMBER:**
FACILITY CONTACT: Timothy M Summers, MPH, RPh	☐ public ☐ private	**CONTACT PHONE NUMBER:** 518-713-2068	**CONTACT FAX NUMBER:** 518-713-2067
CONTACT EMAIL ADDRESS: tsummers@radiopharmacy.com			
OWNER INFORMATION			
OWNER NAME: PharmaLogic Holdings Corp	**OWNER PHONE NUMBER:** 561-416-0085	**OWNER FAX NUMBER:** 561-416-0083	
OWNER ADDRESS: 5301 N Federal Hwy	**OWNER CITY:** Boca Raton	**STATE:** Fl	**ZIP CODE:** 33487
OWNER CONTACT: Steven Chilinski	**OWNER CONTACT EMAIL ADDRESS:** schilinski@radiopharmacy.com		
OPERATOR INFORMATION			
OPERATOR NAME: Timothy M. Summers, MPH, RPh ☐ *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 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)							
Other Biohazard Waste (specify amount for each contaminated material including biohazard incident waste, human remains management waste, etc.)							
Radioactive Waste (specify for each very short lived, short lived or long lived)	0.361	0.398					
Pharmaceutical Waste							
Hazardous Waste							
Other (specify amount for each material including hydrolysate, ash, C&D, etc. requiring further processing.)							
TOTAL	0.361						

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__X__No

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

1/10/23
Date

Timothy M. Summers, MPH, RPh
Name (Print or Type)

Regional Pharmacy Manager
Title (Print or Type)

tsummers@radiopharmacy.com
Email (Print or Type)

14 Walker Way, Suite 5
Address

Albany
City

NY 12205
State and Zip

(518)713 - 2068
Phone Number

ATTACHMENTS: ☐ YES ☐ NO

Reprinted (12/17)

Clear Form

Quarterly REPORT

This Regulated Medical Waste Facility Annual Report is for the year of operation from October 1st through December 31,2022

SECTION 1 – FACILITY INFORMATION

FACILITY INFORMATION			
FACILITY NAME: PharmaLogic Albany			
FACILITY LOCATION ADDRESS: 14 Walker Way, Suite 5	**FACILITY CITY:** Albany	**STATE:** NY	**ZIP CODE:** 12205
FACILITY TOWN: Colonie	**FACILITY COUNTY:** Albany	**FACILITY PHONE NUMBER:** 518-713-2068	
FACILITY NYS PLANNING UNIT: (A list of NYS Planning Units can be found at the end of this report). **Colonie (Town)**		**NYSDEC REGION #:** 4	
360 PERMIT #: 4-0126-00642-0003	**DATE ISSUED:** 12/12/07	**DATE EXPIRES:**	**NYS DEC ACTIVITY CODE OR REGISTRATION NUMBER:**
FACILITY CONTACT: Timothy M Summers, MPH, RPh	☐ public ☐ private	**CONTACT PHONE NUMBER:** 518-713-2068	**CONTACT FAX NUMBER:** 518-713-2067
CONTACT EMAIL ADDRESS: tsummers@radiopharmacy.com			
OWNER INFORMATION			
OWNER NAME: PharmaLogic Holdings Corp	**OWNER PHONE NUMBER:** 561-416-0085	**OWNER FAX NUMBER:** 561-416-0083	
OWNER ADDRESS: 5301 N Federal Hwy	**OWNER CITY:** Boca Raton	**STATE:** Fl	**ZIP CODE:** 33487
OWNER CONTACT: Steven Chilinski	**OWNER CONTACT EMAIL ADDRESS:** schilinski@radiopharmacy.com		
OPERATOR INFORMATION			
OPERATOR NAME: Timothy M. Summers, MPH, RPh ☐ *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 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)							
Other Biohazard Waste (specify amount for each contaminated material including biohazard incident waste, human remains management waste, etc.)							
Radioactive Waste (specify for each very short lived, short lived or long lived)	0.075	0.00					
Pharmaceutical Waste							
Hazardous Waste							
Other (specify amount for each material including hydrolysate, ash, C&D, etc. requiring further processing.)							
TOTAL	0.075						

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__X No

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.

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Bureau of Permitting and Planning
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Fax 518-402-9041
Email address: SWMFannualreport@dec.ny.gov

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Signature

1/10/23
Date

Timothy M. Summers, MPH, RPh
Name (Print or Type)

Regional Pharmacy Manager
Title (Print or Type)

tsummers@radiopharmacy.com
Email (Print or Type)

14 Walker Way, Suite 5
Address

Albany
City

NY 12205
State and Zip

(518)713 - 2068
Phone Number

ATTACHMENTS: ☐ YES ☐ NO

Reprinted (12/17)

Quarterly

Clear Form

~~ANNUAL~~ REPORT

This Regulated Medical Waste Facility Annual Report is for the year of operation from July 1st through September 1st, ~~2021~~ 2022

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OPERATOR NAME: Timothy M. Summers, MPH, RPh ☐ *same as owner*		☐ public ☒ private	
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RMW (Including: Cultures and Stocks, Human Pathological Waste, Human Blood and Blood Products, Sharps, and Animal Waste)							
Other Biohazard Waste (specify amount for each contaminated material including biohazard incident waste, human remains management waste, etc.)							
Radioactive Waste (specify for each very short lived, short lived or long lived)	0.133	~~0.00~~ 0.3182					
Pharmaceutical Waste							
Hazardous Waste							
Other (specify amount for each material including hydrolysate, ash, C&D, etc. requiring further processing.)							
TOTAL	0.133						

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					

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Albany, New York 12233-7260
Fax 518-402-9041
Email address: SWMFannualreport@dec.ny.gov

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Signature

12/15/22
Date

Timothy M. Summers, MPH, RPh
Name (Print or Type)

Regional Pharmacy Manager
Title (Print or Type)

tsummers@radiopharmacy.com
Email (Print or Type)

14 Walker Way, Suite 5
Address

Albany
City

NY 12205
State and Zip

(518)713 - 2068
Phone Number

ATTACHMENTS: ☐ YES ☐ NO

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