#### YEARLY REPORT

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

S	SECTIO	N 1 – FAC	ILITY INFORMATIO	)N					
· · · · · · · · · · · · · · · · · · ·		FACILITY	INFORMATION						
FACILITY NAME: PharmaLogic Albany									
FACILITY LOCATION ADDRES	FACILITY LOCATION ADDRESS: FACILITY CITY: STATE: ZIP CODE:								
14 Walker Way, Suite 5     Albany     NY     12205									
FACILITY TOWN:		FACILITY	Y COUNTY:			ONE NUMBER:			
	Colonie Albany 518-713-2068								
FACILITY NYS PLANNING UNIT report). Colonie (Town)	「:(A list of N	VYS Planning	Units can be found at the end	d of this		IYSDEC EGION #:			
360 PERMIT #: 4-0126-00642-0003	DATE IS 12/12/07		DATE EXPIRES:			TIVITY CODE OR ON NUMBER:			
FACILITY CONTACT: Timothy M Summers, MPH, RF	public private				NTACT FAX NUMBER: 3-713-2067				
CONTACT EMAIL ADDRESS: t		s@radiopl		<u> </u>		<del>_</del>			
OWNER INFORMATION									
OWNER NAME: PharmaLogic Holdings Corp			PHONE NUMBER:		NER FAX 416-0083	NUMBER:			
OWNER ADDRESS:		OWNER			STATE				
5301 N Federal Hwy		Boca Rat	ton		FI	33487			
OWNER CONTACT: Steven Chilinski		schilinsk	CONTACT EMAIL ADD ki@radiopharmacy.com		Š:				
	(	DPERATO	R INFORMATION						
OPERATOR NAME: S <sup>a</sup> Timothy M. Summers, MPH, RPh	me as owne				_ public _ privat	c te			
			FERENCES						
Preferred address to receive correspondence Facility location address									
Other (provide):	Preferred email address: Tracility Contact Owner Contact								
Preferred individual to receive cor Other (provide):	Preferred individual to receive correspondence: Facility Contact Owner Contact								
Did you operate in 2022? 🗡 Ye	es; Comp	lete this forr	n.						

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: <u>http://www.dec.ny.gov/chemical/52706.html</u>.

#### 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)
<b>RMW</b> (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				<u> </u>	
TOTAL WASTE					

SECTION 4 – UNAUTHORIZED SOLID WASTE facility during the reporting period?

Has unauthorized solid waste been received at the facility during the reporting period?

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 No

IX 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

□Yes

If yes, attach additional sheets identifying each problem and the methods for resolution of the problem.

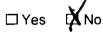
#### **SECTION 7 – CHANGES**

Were there any changes from approved reports, plans, specifications, and permit conditions?

Vo 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?



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

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

(<u>518</u>)713 - 2068 Phone Number

ATTACHMENTS: YES NO

Reprinted (12/17)

#### **Quarterly REPORT**

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

#### **SECTION 1 – FACILITY INFORMATION**

		FACILITY	INFORMATION			· · · · ·		
FACILITY NAME: PharmaLogic Albany		• • • • <u>•</u> • •• • • • • • • • • • •			<u></u>			
FACILITY LOCATION ADDRES	SS:	FACILITY Albany	CITY:		STATE: NY	ZIP CODE: 12205		
FACILITY TOWN: Colonie		FACILITY Albany	COUNTY:		LITY PHO 713-2068	NE NUMBER:		
FACILITY NYS PLANNING UNIT report). Colonie (Town)	「:(AlistofN	VYS Planning	Units can be found at the end	d of this		SDEC GION #:		
360 PERMIT #: 4-0126-00642-0003	DATE IS 12/12/07		DATE EXPIRES:			VITY CODE OR N NUMBER:		
FACILITY CONTACT: Timothy M Summers, MPH, Rf	CONTACT PHONE NUMBER: 518-713-2068		CONTACT 518-713-20	FAX NUMBER: 067				
CONTACT EMAIL ADDRESS:		s@radioph						
		-	INFORMATION	• · · · •				
OWNER NAME: PharmaLogic Holdings Corp			PHONE NUMBER:		IER FAX N 16-0083	NUMBER:		
OWNER ADDRESS: 5301 N Federal Hwy		OWNER Boca Rat	ton		STATE: FI	ZIP CODE: 33487		
OWNER CONTACT: Steven Chilinski			CONTACT EMAIL ADE i@radiopharmacy.cor		:			
	(	OPERATO	RINFORMATION					
OPERATOR NAME: Timothy M. Summers, MPH, RPh	me as owne	r		ג ו	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								
Did you operate in 20222 Xes: Complete this form								

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: <u>http://www.dec.ny.gov/chemical/52706.html</u>.

#### 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)
<b>RMW</b> (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 hydrotysate, 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 facility during the reporting period?

Has unauthorized solid waste been received at the facility during the reporting period?

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

YZI 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

□Yes

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?

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?



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 <u>A</u> misdemeanor pursuant to Section 210.45 of the Penal Law.

Signature

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

(<u>518</u>)713 - <u>2068</u> Phone Number

ATTACHMENTS: YES NO

Reprinted (12/17)

## Clear Forn

# Quarterly ANNUAL REPORT

This Regulated Medical Waste Facility Annual Report is for the year of operation from July 1<sup>st</sup> through September 1st, 2009, 400 22

"Inactive Solid Waste Management Facility or Activity Notification Form" located at:



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<b>SECTION 1</b>	- FACILITY	INFORMATION

		FACILITY	INFORMATION		UK CE I	「「「「」」	
FACILITY NAME:			· · · · · · · · · · · · · · · · · · ·				
PharmaLogic Albany							
FACILITY LOCATION ADDRE	<u></u>	FACILIT			OTATE.		
14 Walker Way, Suite 5	33:	Albany			STATE: NY	ZIP CODE: 12205	
14 Walkel Way, Suite 5		Albally				12205	
FACILITY TOWN: Colonie		Albany	COUNTY:		LITY PHC 13-2068	ONE NUMBER:	
Colonie		Albany		516-7	13-2000		
	<u> </u>						
FACILITY NYS PLANNING UNI	T: (A list of I	NYS Planning	Units can be found at the en	d of this		SDEC	
report). Colonie (Town)						GION #:	
				÷ .	4		
360 PERMIT #:	DATE IS	SSUED:	DATE EXPIRES:	NYSI	DEC ACTI	VITY CODE OR	
4-0126-00642-0003	12/12/07	7				N NUMBER:	
FACILITY CONTACT:		public	CONTACT PHONE	,   /		FAX NUMBER:	
FACILITY CONTACT.	1		NUMBER:		518-713-2		
Timothy M Summers, MPH, R	Ph	private	518-713-2068		010-713-2	007	
CONTACT EMAIL ADDRESS:		s@radion		I			
			INFORMATION				
OWNER NAME:							
PharmaLogic Holdings Corp					OWNER FAX NUMBER: 561-416-0083		
OWNER ADDRESS:		OWNER	CITY:		STATE:	ZIP CODE:	
5301 N Federal Hwy		Boca Ra	ton		FI	33487	
OWNER CONTACT:		OWNER	CONTACT EMAIL ADI	DRESS	:	<b>1</b>	
Steven Chilinski		schilins	(i@radiopharmacy.co)	m			
			RINFORMATION	· · · · · ·			
OPERATOR NAME: Simothy M. Summers,	ame as owne	r		E	- public		
MPH, RPh				9	private		
		DRE	FERENCES				
Preferred address to receive co	prresponde		ity location address		Owner a	ddrass	
Other (provide):	neoponac		ny locadon address		Owner a	00/035	
· · ·			· · · · ·				
Breferred email address: 🎾 🖬 Other (provide):	cility Conta	ct L	Owner Contact				
Preferred individual to receive co	prresponde	ence: : 🗶	Facility Contact	Owner	Contact		
Other (provide):		<b>2</b> ·	-				
						· · · · · · · · · · · · · · · · · · ·	
	<u> </u>				-		
Did you operate in 2022? 💢 Y	/es; Comp	lete this for	n.				
			mit Sections 1 and 10. If				
wish to relinquish your permit/reg	pistration a	ssociated w	ith this solid waste mana	gement	t activity, a	iso complete the	

http://www.dec.ny.gov/chemical/52706.html .

#### SECTION 2 – PERMITTED RMW WASTE TRANSFER OR TREATMENT FACILITIES

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<b>RMW</b> (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	03182 03182					
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					<b>1</b>

# SECTION 4 – UNAUTHORIZED SOLID WASTE facility during the reporting period?

Has unauthorized solid waste been received at the facility during the reporting period?

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

□Yes

No If yes, attach additional sheets identifying each problem and the methods for resolution of the problem.

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Were there any changes from approved reports, plans, specifications, and permit conditions?

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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

12/15/22

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 Citv

NY 12205

State and Zip

(<u>518</u>)713 - 2068 Phone Number

ATTACHMENTS: YES NO

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