



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: | | | |
| FACILITY LOCATION ADDRESS: | FACILITY CITY: | STATE: | ZIP CODE: |
| FACILITY TOWN: | FACILITY COUNTY: | FACILITY PHONE 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 ISSUED: | DATE EXPIRES: | NYS DEC ACTIVITY CODE OR REGISTRATION NUMBER: |
| FACILITY CONTACT: | <input type="checkbox"/> public <input type="checkbox"/> private | CONTACT PHONE NUMBER: | CONTACT FAX NUMBER: |
| CONTACT EMAIL ADDRESS: | | | |
| OWNER INFORMATION | | | |
| OWNER NAME: | OWNER PHONE NUMBER: | OWNER FAX NUMBER: | |
| OWNER ADDRESS: | OWNER CITY: | STATE: | ZIP CODE: |
| OWNER CONTACT: | OWNER CONTACT EMAIL ADDRESS: | | |
| OPERATOR INFORMATION | | | |
| OPERATOR NAME: <input type="checkbox"/> same as owner | | <input type="checkbox"/> public <input type="checkbox"/> private | |
| PREFERENCES | | | |
| Preferred address to receive correspondence: <input type="checkbox"/> Facility location address <input type="checkbox"/> Owner address <input type="checkbox"/> Other (provide): | | | |
| Preferred email address: <input type="checkbox"/> Facility Contact <input type="checkbox"/> Owner Contact <input type="checkbox"/> Other (provide): | | | |
| Preferred individual to receive correspondence: <input type="checkbox"/> Facility Contact <input type="checkbox"/> Owner Contact <input type="checkbox"/> 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 <i>(See Attached List of NYS Planning Units)</i> |
|---|--|---|--|------------------------|--|--|---|
| RMW (Including: Cultures and Stocks, Human Pathological Waste, Human Blood and Blood Products, Sharps, and Animal Waste) | 136.5 | 3.7 | 132.8 | | | Stericycle, Inc. 798 Hartwell Ave East Syracuse, NY | |
| Other Infectious Waste <i>(specify amount for each contaminated material including infectious incident waste, human remains management waste, etc.)</i> | | | | | | | |
| Radioactive Waste <i>(specify for each very short lived, short lived or long lived)</i> | | | | | | | |
| Pharmaceutical Waste | | | | | | | |
| Hazardous Waste | | | | | | | |
| Other <i>(specify amount for each material including hydrolysate, ash, C&D, etc. requiring further processing.)</i> | Carcass: 283.1 Bedding: 29.6 Wood Waste: 0.0 | Carcass: 2.0 Bedding: 0.0 Wood Waste: 0.0 | Carcass: 281.1 Bedding: 29.6 Wood Waste: 0.0 | | | Stericycle, Inc. 798 Hartwell Ave East Syracuse, NY | |
| TOTAL | | | | | | | |

SECTION 3 – DISPOSAL DESTINATION

| WASTE TYPE | AMOUNT (tons) | FACILITY NAME AND ADDRESS | STATE | COUNTY | NYS PLANNING UNIT <i>(See Attached List of NYS Planning Units)</i> |
|--------------------|------------------|---------------------------|-------|--------|---|
| 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.

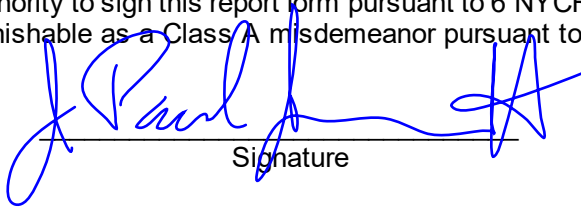
SECTION 9 - SIGNATURE AND DATE BY OWNER OR OPERATOR

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.)

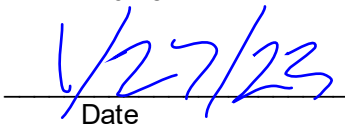
The Owner or Operator must also submit one copy by email, fax or mail to:

**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.



Signature



Date

Name (Print or Type)

Title (Print or Type)

Email (Print or Type)

Address

City

State and Zip

() - _____
Phone Number
607-253-4227

ATTACHMENTS: ____ YES ____