



DH use only: Check No. _____ Check Amount _____	
Date Received _____	Receipt No. _____
Permit No. _____	Date Issued _____

# Department of Health

## Application for Biomedical Waste Generator Permit/Exemption

A biomedical waste generator is required to apply for an annual biomedical waste permit and abide by the requirements of Chapter 64E-16, Florida Administrative Code (F.A.C.). The initial permit fee is \$85.00. Permits expire September 30 of each year. The permit fee for renewal applications received by October 1 is \$85.00. The permit fee for renewal applications received after October 1 is \$105.00. State-owned and operated facilities are exempt from the permit fee. Submit the following information on this form to your local Department of Health Biomedical Waste Coordinator.

**FOR CURRENTLY PERMITTED GENERATORS ONLY:** A currently permitted biomedical waste generator, that produces **less than 25 pounds of biomedical waste** in each 30 day period, may claim an exemption from the fee and permitting requirements only of Chapter 64E-16, F.A.C. **A currently permitted biomedical waste generator applying for exemption from permitting must submit documentation from the previous 12 months showing the biomedical waste generated in each 30 day period during those 12 months was less than 25 lbs. Documentation must include the amount of waste generated in each 30 day period for the previous 12 months and may be in the form of a monthly log or receipts.**

- Application for (choose one): \_\_\_\_\_ Permit \_\_\_\_\_ Exemption (attach appropriate documentation)  
(Applicant must be a legal entity, i.e.: individual, partnership, corporation, association, or public body)
- Facility Name: \_\_\_\_\_
- Facility Address: \_\_\_\_\_  
Street City State Zip Code
- Contact Person: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_
- Name of Facility Owner: \_\_\_\_\_
- Mailing Address of Facility Owner: \_\_\_\_\_  
Street City State Zip Code
- Business Phone: ( ) \_\_\_\_\_ 24-Hour Emergency Phone: ( ) \_\_\_\_\_
- Name of Property Owner: \_\_\_\_\_
- Mailing Address of Property Owner: \_\_\_\_\_  
Street City State Zip Code
- Type of Waste Generated: \_\_\_\_\_ Sharps \_\_\_\_\_ Non-sharps
- Method of Removal (Check One):  
1. By applicant, to where: \_\_\_\_\_  
2. By transporter, company name: \_\_\_\_\_
- Maximum weight of biomedical waste generated during any 30-day period: \_\_\_\_\_ lbs.
- Branch Offices: \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, attach sheet with complete name, address and phone number of branch office(s).

Check Type of Facility:

01. Hospital	07. Dentist	13. Surgical Center/Walk-in Clinic
02. Funeral Home	08. Podiatrist	14. Blood Banks
03. Dialysis Clinic	09. Osteopath	16. Abortion Clinics
04. Nursing Home	10. Home Health	17. Other (specify)
05. Veterinarian	11. State Laboratory/Clinic	18. Tattoo/Body Piercing
06. Medical Doctor	12. Clinical Laboratory	

The undersigned owner/owner's representative hereby agrees to operate the biomedical waste generating facility described in this application in accordance with the requirements of Section 381.0098, Florida Statutes, and Chapter 64E-16, F.A.C. The information contained in this application, which serves as a basis for permitting or exemption, is true and correct. I understand that any misrepresentation of the facts in this application, or failure to comply with sanitary standards, is grounds for denial, administrative fine or revocation of the biomedical waste permit or exemption. Biomedical waste shall be handled within the facility in accordance with the generator's written operating plan. Operating plan must be in compliance with 64E-16, F.A.C.

\_\_\_\_\_  
Signature of Authorized Representative      Name of Authorized Representative (print or type)      Date