West Virginia Infectious Medical Waste Program  
Office of Environmental Health Services  
350 Capitol Street, Room 313  
Charleston, WV  25301-3713

180-DAY WASTE EVALUATION AGREEMENT

Facility Name: ____________________________________________________________

Address: ______________________________________________________________________

Telephone: _______________________________    Fax: _______________________________

Owner / Agent: _____________________________    Email: ____________________________

• I hereby acknowledge that the above facility is currently generating in excess of fifty pounds of infectious medical waste per month.

• Pursuant to the West Virginia Infectious Medical Waste Rule, 64 CSR 56, this facility is required to apply for a permit with the West Virginia Bureau for Public Health.

• In the interest of protecting and preserving the environment, as well as decreasing the overall operating costs of this facility, I am requesting a 180 day waste evaluation period.

  During this time I will be evaluating what items are currently being disposed in biohazard containers. I will also be reviewing and studying the guidance document provided by the WV Medical Waste Program as well as my copy of the West Virginia Rule.

  By reviewing these documents I hope to better understand the requirements for waste classification and disposal. The goal of this evaluation is to reduce of the amount of over-classification of noninfectious waste as infectious waste. This will enable the facility to eliminate unnecessary infectious waste disposal and potentially drop the facility below the regulatory limit for permitting.

• I acknowledge that if after ninety days this facility is unable to reduce the amount of infectious medical waste it generates, it will be required to begin the application for permit process.

• I acknowledge that if this waste reduction effort is successful, but in the future this facility again increases its waste generation, it will be subject to the permit requirements.

• I hereby agree to use this 180-day evaluation period to review the infectious medical waste management practices of the above named facility.

_____________________________________                                   _______________________

Owner/Agent Signature                                    Date