

IMW-10
08-02

**INFECTIOUS MEDICAL WASTE
LARGE QUANTITY GENERATORS REPORT
FOR THE CALENDAR YEAR OF _____**

A. FACILITY NAME _____ IMW PERMIT NO. _____
ADDRESS _____ CITY _____ ZIP _____
PERSON COMPLETING REPORT _____
TITLE _____ PHONE NUMBER _____ EXT. _____

B. INFECTIOUS MEDICAL WASTE MANAGEMENT INFORMATION

TOTAL WEIGHT GENERATED ON SITE THIS YEAR (LBS.) _____

TOTAL WEIGHT RECEIVED FROM OFF SITE THIS YEAR (LBS.) _____

C. TRANSPORTER INFORMATION (complete only if applicable)

TRANSPORTERS NAME _____
ADDRESS _____
PHONE _____

TOTAL WEIGHT TRANSPORTED THIS YEAR (Lbs. 9 or Boxes 9) _____

FEEES BY 9 BOX \$ _____ EACH or 9 POUND \$ _____ EACH SERVICE FEE \$ _____
(Attach photo copy of ten completed manifests)

D. IMW TREATMENT (complete all that apply)

NOTE: AMOUNTS GENERATED AND RECEIVED MUST EQUAL THAT TREATED AND TRANSPORTED

9 INCINERATION (ON SITE ONLY)

TOTAL WEIGHT INCINERATED THIS YEAR (LBS.) _____

LIST OPERATOR NAMES _____

(Attach phot copies of quarterly total fixed carbon and annual heavy metal sample result-TCLP)

9 STEAM TREATMENT (ON SITE ONLY)

TOTAL WEIGHT TREATED THIS YEAR (LBS.) _____

OPERATIONAL PARAMETERS USES

TEMP. EF _____ TIME IN MIN. _____ PRESSURE (psi) _____

(STEAM TREATMENT CONTINUED)

LIST OPERATOR NAMES

(Attach photo copies of Bacillus stearothermophilus spore studies)

9 ALTERNATIVE METHOD (ON SITE ONLY)

SPECIFY METHOD

TOTAL WEIGHT TREATED THIS YEAR (LBS.)

LIST OPERATOR NAMES

(Attach photo copies of laboratory reports verifying treatment.)

LIST THE LANDFILL THAT RECEIVES YOUR TREATMENT RESIDUE

NAME

CONTACT

ADDRESS

PHONE

I hereby certify that to the best of my knowledge the information contained on this report is accurate.

Signature of person completing report

Date completed