

West Virginia Department of Health and Human Resources
Office of Environmental Health Services
Infectious Medical Waste Program



Infectious Medical Waste Transporter Quarterly Report

Quarter _____

Year _____

A. Transporter company name _____
Person completing report _____ Title _____
Email address _____
Phone number _____ Fax number _____
Vehicle permits IMW-99-_____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____

B. Infectious waste transported from WV facilities - Quarter (lbs. tons) _____
Infectious waste transported from WV facilities - Year to Date _____
Number of vehicles permitted and used in WV for waste transport _____
Number of WV large quantity generators (50 lbs. per month or more) _____
Weight of infectious waste from WV large quantity generators _____
Number of WV small quantity generators _____

Do you operate an Infectious Waste Management Facility (transfer station) in WV? YES NO
Permit Number IMW-99-_____-_____

Is waste commingled at your WV waste management facility prior to shipping? YES NO

C. Infectious waste transported into WV for treatment - Quarter (lbs. tons) _____
Infectious waste transported into WV for treatment - Year to Date _____
Number of vehicles permitted and used in WV for waste transport _____
Do you operate an Infectious Waste Management Facility (transfer station)? YES NO
Location: _____ Permit Number _____

D. Treatment Facility: (Note: if more than two are used, complete additional sheets as needed)
Name _____ Name _____
Location _____ Location _____
Contact _____ Contact _____
Phone _____ Phone _____
Permit Number _____ Permit Number _____

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