| Logo for the Virginia Department of Environmental Quality | Regulated Medical Waste Management Facility  PBR Application Form |
| --- | --- |

Please specify, is this application for a  New Facility or  PBR Modification

# FACILITY INFORMATION

## Facility Information

**Facility Name:**       **Permit No. PBR**

**Location Address:**

**City, State, Zip:**

**Latitude:**       Deg       Min      Sec North **Longitude:**       Deg       Min      Sec West

**Tax Map, Parcel ID:**       **County:**

**Total Property Acreage:**       acres **RMW Management Area:**       square feet

## Facility Contact Information

**Contact Person:**       **Contact Title:**

**Contact Phone:**       **Contact E-mail:**

**Owner:**       **Operator:**

**Mailing Address:**       **Mailing Address:**

**City, State, Zip:**       **City, State, Zip:**

## Regulated Medical Waste Generation

**Where is RMW Generated?** :  Onsite  Offsite  Both

**RMW Source (check all that apply):**

Dentist’s Office, Clinic, Oral Surgery Center, or similar Dental Facility

Doctor’s Office, Clinic, Hospital, or similar Health Care Facility

Nursing Home, Assisted Living, or Home Health Facility

Research Facility, Diagnostic Laboratory, or similar

University or Educational facility

Veterinarian Practice, Animal Research, or similar Animal Care Facility

Other, please specify:

### **RMW Facility Type (check all that apply):**

Transfer Station

Treatment

**Facility Process Rate:**       (include units as weight or volume per day)

**RMW Storage Capacity:**       Specify Units **Treated Waste Storage Capacity:**       Specify Units

**Is Refrigerated RMW Storage available?**  Yes  No

**Is there a Reusable Cart Washing Station?**  Yes  No

**Disposition of Treated or Transferred Wastes:**

**Hours of Operation:**

# TREATMENT UNIT INFORMATION

Fill out a separate Section II for each treatment unit located at the facility.

## Treatment Unit Specifics N/A

**Device Trade Name:**       Unit       of

**Model Number:**

**Unit Location:**

**Treatment Type:**

Alkaline Hydrolysis  Autoclave  Chemical Treatment

Dry Heat Treatment  Incineration  Microwave

Alternate Treatment, specify:

**Treatment Indicator Parameters: (check all that apply)**

| Indicator Parameter | Operation Setting | Recording Method |
| --- | --- | --- |
| Temperature: |  | Specify |
| Pressure: |  | Specify |
| Time: |  | Specify |
| Chemical Concentration: |  | Specify |

Other (Please specify):

**Proposed Biological Indicator:**

**Treatment Cycle Time:**       Specify Units

**Max Loading Rate per cycle:**       Specify Units

## Types of RMW to be Treated (check all that apply)

Animal carcasses or body parts  Mixed RMW and solid waste

Animal bedding and related wastes  Non-hazardous Pharmaceuticals

Category A wastes  Prion waste

Chemo and/or Radioactive Wastes (transfer only)  Residues

Cultures and Stocks  Sharps

Human blood and body fluids  Solidified liquids

Human pathological and anatomical waste  Toxins or toxin waste solutions

Other Wastes, please list:

## Wastewater Management (check all that apply)

Discharged directly to WWTP Transported by vehicle to offsite WWTP

Treated onsite and discharged  Other, please specify:

# TRANSFER STATION

## Types of RMW to be Transferred (check all that apply) N/A

Animal carcasses or body parts  Mixed RMW and solid waste

Animal bedding and related wastes  Non-hazardous Pharmaceuticals

Category A wastes  Prion waste

Chemo and/or Radioactive Wastes (transfer only)  Residues

Cultures and Stocks  Sharps

Human blood and body fluids  Solidified liquids

Human pathological and anatomical waste  Toxins or toxin waste solutions

Other Wastes, please list:

## Wastewater Management (check all that apply)

Discharged directly to WWTP Transported by vehicle to offsite WWTP

Treated onsite and discharged  Other, please specify:

# PBR APPLICATION ATTACHMENTS

The following items shall be provided as an attachment to this form and will constitute the facility’s Permit-by-Rule application. Please indicate whether each item is ‘provided’ or ‘not applicable’ to the proposed facility or facility modification.

| Permit-by-Rule Application Attachment | Provided | N/A |
| --- | --- | --- |
| 1. Notice of Intent |  |  |
| 1. Disclosure Statement, DEQ Forms DISC-01 and DISC-02 |  |  |
| 1. Waste Management Facility Operator Certification |  |  |
| 1. Local Government Certification and Solid Waste Management Plan Consistency Certification, DEQ Form CERT-01 |  |  |
| 1. Public Participation Summary |  |  |
| 1. Certification of Siting Standards, 9 VAC 20-121-210 |  |  |
| 1. P.E. Certification of Design/Construction Standards, 9 VAC 20-121-220 |  |  |
| 1. Design Plans, 9 VAC 20-121-310.A.2.d. |  |  |
| 1. Documentation of authorization to discharge to Sanitary Sewer / POTW |  |  |
| 1. Certification that the Facility meets the Standards of Part III (9VAC20-121-100 et seq.) and Part IV (9VAC20-121-200 et seq.), as applicable |  |  |
| 1. Copy of the Regulated Medical Waste Management Plan in accordance with 9VAC20-121-330 |  |  |
| 1. Statement that the Emergency Contingency Plan has been provided to the local police and fire departments, local emergency manager, and a local emergency health coordinator |  |  |
| 1. Alternate Treatment Technology Approval |  |  |
| 1. Treatment Plan, 9 VAC 20-121-330.E. |  |  |
| 1. For Treatment Facilities, a Treated Waste Disposal Plan, 9 VAC 20-120-280.D. |  |  |
| 1. Closure Plan, 9 VAC 20-121-330.G. |  |  |
| 1. Demonstration of legal control over the site |  |  |
| 1. State Corporation Commission Certification |  |  |
| 1. Closure Cost Estimate and Proof of Financial Assurance |  |  |
| 1. Permit Fee specified under 9 VAC 20-90 |  |  |
| 1. Copies of other DEQ Media Permits (Air, VPDES, etc.) |  |  |
| 1. Variance Petition in accordance with 9 VAC 20-121-400   If provided, please indicate the regulatory citation for variance: |  |  |

# RESPONSIBLE OFFICIAL SIGNATURE

I certify under penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system or those persons directly responsible for gathering the information, the information submitted is to the best of my knowledge and belief true, accurate, and complete.

SIGNATURE: DATE:

NAME:

TITLE: