County of San Diego

DEPARTMENT OF ENVIRONMENTAL HEALTH & QUALITY
HAZARDOUS MATERIALS DIVISION
P.O. BOX 129261, SAN DIEGO, CA 92112-9261
(858) 505-6880 FAX (858) 505-6848
http://www.sdcdeh.org

Onsite Medical Waste Treatment Permit Application

Owner and Operator Information *22 CCR 65625 (a)(1)*

Facility Owner	**Owner Phone Number**
Owner Business Address or PO Box	**Owner City/ZIP**
Ownership Status ☐ Private Entity ☐ Federal Gov't ☐ State Gov't ☐ Local Gov't ☐ Other	
Facility Operator (if different from owner)	**Operator Phone Number**
Operator Business Address or PO Box	**Operator City/ZIP**

Facility Information *22 CCR 65625 (a)(2-3)*

Facility Name	**Unified Program Facility Permit #**
Facility Street Address	**Facility City/ZIP**
Mailing Address (if different from above)	**Mailing City/ZIP**
Business Description	

Facility Contact Person(s)

Primary Contact Name	
Title	**Phone**
Secondary Contact Name	
Title	**Phone**

Facility Status *22 CCR 65625 (a)(4)*

1 Check the appropriate box indicating whether this application is for facility with a new or existing Unified Program Facility Permit (UPFP).

☐ **New** Facility Permit *(skip question 2)*

☐ **Existing** Facility Permit *(see question 2)*

2 **Existing Facilities:** Check the appropriate box for your medical waste treatment permit request.

☐ **Permit Revision**

☐ **Transfer of Ownership**

☐ **Permit Renewal**

Medical Waste Treatment Equipment

3 Check the appropriate box indicating which method of onsite treatment you are applying for:
HSC §118215

☐ **Steam Sterilization** *(see question 8)*

☐ **Incineration**

☐ **Alternative High-Heat Treatment Method**

☐ **Other CDPH Approved Treatment Method**
The current list is available on CDPH Medical Waste Program website.
Which Method?:

4 How many treatment units do you plan to have?:

5 Do you plan on treating any medical waste generated offsite?: ☐ **Yes** ☑ **No**

6 What is the average number of pounds you expect to treat in one month?:

7 Describe the process to be used for disposal of treated wastes (*ATTACH ADDITIONAL PAGES*)

8 For STEAM STERILIZATION: Please include the following information for **EACH** treatment unit (*ATTACH ADDITIONAL PAGES*) *HSC §118215* **Contact the HMD for all other treatment methods.**

- Standard Written Operating Procedure with:
  - Manufacturer Name, Model number, and Serial number
  - Time, Temperature, Pressure
  - Type of waste(s)
    - For Sharps waste: Include how you plan to destroy or prevent public access to treated sharps waste prior to disposal *HSC §118225(c)*
  - Type of container(s) including the closure on the containers
  - Pattern of loading
  - Water content volume
  - Maximum load quantity or weight (in pounds)
  - Heat-sensitive indicator (tape or other method) to be used on each bag or container
- Sterilization Log indicating the following information for every cycle:
  - Run time
  - Temperature reached
  - Pressure reached
  - Type of medical waste treated
  - Number or weight of containers
  - Water content adequate?
  - Was adequate sterilization reached?
    - Adequate sterilization = minimum 121ºC for 30 minutes
  - Did the heat-sensitive tape on each container change color?
  - Was a spore test included in the run? (in lieu of a monthly spore test)
    - Was it placed in the center of the of the load?
    - What was the result?
- Monthly Spore Test Log:
  - Biological Indicator species:
    - *Geobacillus sterothermophilus - or -*
    - Other:
  - This can be used if the monthly spore tests are not included in the Sterilization log
- Annual Calibration Log or related records for thermometer, thermocouple or other monitoring device(s)

Be advised:

- All records listed above are required to be maintained for a minimum of 2 years. *HSC §118225(2)(E)*
- Steam sterilization is not an approved treatment method for pathology waste, trace chemotherapeutic waste or pharmaceutical waste. *HSC §118222*
- All other treatment methods are required to result in the destruction of pathogenic microorganisms. *HSC §118215(a)(3)(A)(ii).* Contact HMD for instructions on providing adequate evidence and documentation.

New or Repaired Equipment Validation Process

All new or repaired autoclave units will be required to go through a validation process to ensure the equipment will adequately sterilize medical waste prior to approval of a medical waste treatment permit. This process will include but will not be limited to:

- 4 consecutive test cycles
- Each test will consist of placing 2-3 Biological Indicators (BI) in specific locations in each run
- Photo documentation and run records

If you need to validate a new or repaired autoclave unit, contact the Medical Waste Lead at HMD for specific protocol.

*Per HSC §118215(c), for liquid or semi-liquid biohazardous laboratory waste (§117690(b)(1)(B)), the treatment method must be recognized by the NIH, the CDC, or the American Biological Safety Association. If the chemical disinfection of the medical waste causes the waste to become a hazardous waste, the waste shall be managed in accordance with the requirements of HSC Chapter 6.5 (commencing with §25100) of Division 20.

Training Plan *HSC §117938; §117967*

9 Outline both the introductory and continuing training program for all employees generating and treating medical waste to include but no limited to:

- Operation of treatment equipment
- Proper protective equipment to wear
- How to clean up spills
- Any other information required to operate the treatment equipment in a safe and effective manner

Include a brief description of how training will be designed to meet actual job tasks. *(ATTACH ADDITIONAL PAGES)*

Emergency Action Plan *HSC §118235*

10 Please describe how the facility plans to ensure the proper disposal of medical waste in the event of

- Equipment Breakdown
- Natural Disasters (Earthquake, Wildfires, etc.)
- Other Occurrences (Power Outages, Fire, Flood, etc.)

Closure Plan *HSC §117935(j)*

11 Describe the closure plans for the termination of treatment at the facility including **but not limited** to the method of decontamination thereby rendering the property to an acceptable sanitary condition following the completion of treatment services at the site. *(ATTACH ADDITIONAL PAGES)*

Check the appropriate box indicating which method of disinfection you will use in your closure plan:
HSC §118295 (a) and (b)

- ☐ **Exposure to hot water 180ºF for ≥ 15 seconds**
- ☐ **Rinse/Immersion in hypochlorite solution for ≥ 3 minutes** (500 ppm available chlorine)
- ☐ **Rinse/Immersion in phenolic solution for ≥ 3 minutes** (500 ppm active agent)
- ☐ **Rinse/Immersion in Iodoform solution for ≥ 3 minutes** (100 ppm available iodine)
- ☐ **Rinse/Immersion in Quaternary ammonium solution for ≥ 3 minutes** (400 ppm available active agent)

Medical Waste Management Plan *HSC §117935; §117960*

12 Complete and submit a Medical Waste Management Plan with this application

Compliance History *HSC §117935(j)*

13 Describe your compliance history under any local, state, or federal law or regulation governing the control of medical waste or pollution, but not limited to the Clean Air Act. Such description shall include all violations at the facility or other facility owned or operated by the applicant within three years of the date of this application. *(ATTACH ADDITIONAL PAGES)*

Acknowledgement

14 I have read and understood, as a medical waste generator with onsite treatment, I am required to comply with the applicable requirements in the Medical Waste Management Act found in the California Health and Safety Code, Sections 117600-118360. ☐ **Yes**

Certification Statement

15 I declare under penalty of law that to the best of my knowledge and belief, the statements made herein are correct and true. I hereby consent to all necessary inspections made pursuant to the California Medical Waste Management Act and incidental to the issuance of my permit or registration and the operation of this business.

Name	**Title**

Signature	**Date**