Department of Health
Application for Biomedical Waste Storage Permit

Pursuant to Chapter 64E-16, Florida Administrative Code (F.A.C.), a facility that stores biomedical waste must obtain an annual permit from the department. The initial permit fee is $85.00. Permits expire September 30 of each year. The permit fee for renewal applications received by October 1 is $85.00. The permit fee for renewal applications received after October 1 is $105.00. State-owned and operated biomedical waste facilities are exempt from the permit fee. Submit the following information on this form to the county health department that has jurisdiction for the biomedical waste program in the county where the storage facility will be located.

1. Application For (Choose One): [ ] New [ ] Renewal
   (Applicant must be a legal entity, i.e.: individual, partnership, corporation, association, or public body)

2. Facility Name:__________________________________________________________

3. Facility Address: _________________________________________________________
   Street __________________________ City __________________________ State ______ Zip Code ______

4. Contact Person: ______________________________________________________________________ Telephone: (____)__________

5. Name of Facility Owner: __________________________________________________________

6. Mailing Address of Facility Owner: _________________________________________________
   Street __________________________ City __________________________ State ______ Zip Code ______

7. Business Phone: (____)____________________________

8. 24-Hour Emergency Phone: (____)____________________________

9. Name of Property Owner: _________________________________________________________

10. Mailing Address of Property Owner: _________________________________________________
    Street __________________________ City __________________________ State ______ Zip Code ______

11. Describe the general layout and operation of the facility or equipment (attach additional sheets, if necessary):
    ____________________________________________________________________________
    ____________________________________________________________________________

12. Date of beginning operation: _________________________________________________

13. List where the biomedical waste will be treated or taken for further storage:
    ____________________________________________________________________________
    ____________________________________________________________________________
    ____________________________________________________________________________

I certify that, to the best of my knowledge, the information provided in this application is true and accurate.

______________________________  ________________________________  ________________
Signature of Authorized Representative  Name of Authorized Representative (print or type)  Date