New York State Department of Environmental Conservation
Division of Materials Management

Revised 2014

Medical Waste Tracking Form

Emergency Response Number:

GENERATOR

1. Generator's Name and Mailing Address:

2. Tracking Form Number:

4. State Permit or ID No.:

3. Telephone number:

5. Transporter's Name and Mailing Address:

6. Telephone Number:

7. State Transporter or ID No.

8. Destination Facility Name and Address:

9. Telephone Number:

10. State Permit or ID No.

11. USDOT Shipping Name:	HM		12. Total No. Containers	13. Total Weight or volume
a.	x	Regulated Medical Waste, 6.2,UN3291,PGII		
b.				

14. Special Handling Instructions:

14.(a) Additional Information

15. Generator's Certification:
I hereby declare, on behalf of the generator _____
that the contents of this consignment are fully and accurately described above by proper shipping name and are classified, packed, marked, and labeled, and are in all respects in proper condition for transport by highway according to applicable international and national government regulations and state laws and regulations.

Print/Type Name Signature Date

INSTRUCTIONS

Instructions for completing the medical waste tracking form:

Copy 1 - GENERATOR COPY: Mailed by Destination Facility to Generator
Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility
Copy 3 - TRANSPORTER COPY: Retained by Transporter
Copy 4 - GENERATOR COPY: Retained by Generator

1. This multi-copy (4 page) shipping document must accompany each shipment of regulated medical waste generated in New York State.
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4,7,10 & 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

TRANSPORTER

16. Transporter 1 (Certification of Receipt of Waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

17. Transporter 2 or Intermediate Handler (Name and Address)

18. Telephone Number

19. State Transporter Permit or ID No.

20. Transporter 2 or Intermediate Handler (Certification of Receipt of Waste as described in items 11, 12 & 13)

Print/Type Name Signature Date

21. New Tracking Form Number (for consolidated or remanifested waste)

DESTINATION

22. Destination Facility (Certificate of Receipt of Medical Waste as described in items 11, 12 & 13)
□ Received in accordance with items 11, 12 & 13

Print/Type Name Signature Date
(If other than destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)