

**NOTICE:** This form is authorized by s.NR526.15, Wis. Adm. Code. Completion of this form is mandatory unless the facility is exempt under both ss.NR 526.14(2) and 526.16(2), Wis Adm. Code. Failure to submit a completed report to the Department of Natural Resources is punishable by a forfeiture of not less than \$10 nor more than \$5000 [s.299.97, Wis. Stats.]. Personally identifiable information on this form will be used for administering the Infectious Waste Program and is not intended to be used for any other purpose.

**DO NOT SEND THE \$55 FILING FEE NOW. You will be billed later.**

**Part I - Facility Information**

Name of Infectious Waste Generator	Facility Identification No. (FID)	Report Year
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**Generator Location DO EXEMPTION STATUS BOX FIRST → Exemption Status Read instructions carefully**

Street Address of Generator	<input type="checkbox"/> Check if exempt from Part II. You may be required to report under Part III. <input type="checkbox"/> Check if exempt from Part III. You may be required to report under Part II. <input type="checkbox"/> Check if exempt from Parts II and III. Go to Part IV, sign and date the report, and send back to DNR. Should DNR send you an annual report next year? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, why not? _____
City State Zip Code	
County	
Owner	

**Part II - Off-Site Treatment Report**

<p><b>Generator Type</b> -Check all that apply</p> <input type="checkbox"/> 170 Hospital <input type="checkbox"/> 171 Nursing Home <input type="checkbox"/> 172 Physician office or clinic <input type="checkbox"/> 173 Dental office or clinic <input type="checkbox"/> 174 Veterinary office or clinic <input type="checkbox"/> 175 Clinical laboratory (freestanding) <input type="checkbox"/> 176 Dialysis clinic (freestanding) <input type="checkbox"/> 177 Other - Specify: _____ If you checked more than one, which one generated the most infectious waste? _____	To be submitted by all infectious waste generators unless exempt. Cross out any incorrect information and update it. First off-site treatment facility name, from manifests Treatment facility address City State Zip Code First Treatment facility DNR Facility Identification Number (FID)
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<p><b>Infectious Waste Type</b> -Check all that apply</p> <input type="checkbox"/> W421 Sharps <input type="checkbox"/> W422 Human tissue <input type="checkbox"/> W423 Bulk blood and body fluids from humans <input type="checkbox"/> W424 Microbiological laboratory waste <input type="checkbox"/> W425 Tissue, bulk blood or body fluids from animals carrying zoonotic infectious agents	Second off-site treatment facility name, from manifests Treatment facility address City State Zip Code Second Treatment facility DNR Facility Identification Number (FID)
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<p><b>Infectious Waste On-site Activities</b> -Total weights in reporting year Please round up to nearest pound.</p> <p>A. Infectious waste generated on-site _____ lbs.                  B. Accepted from other Wisconsin generators _____ lbs.                  C. Accepted from out-of-state generators _____ lbs.                  D. Treated on-site _____ lbs.                  E. Transported off-site for treatment _____ lbs.</p>	Report any additional treatment facilities on an attachment.
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<p><b>FOR DNR USE ONLY - LEAVE BLANK</b></p> <p>Date Stamp - Date form was received</p> <div style="border: 1px solid black; width: 200px; height: 100px; margin: 5px 0;"></div>	<p>Items missing or incomplete:</p> <p>Follow-up done (date, action, initials):</p>
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<input type="checkbox"/> Needs FID <input type="checkbox"/> Verify exemption <input type="checkbox"/> Exempt <input type="checkbox"/> Non-exempt, complete <input type="checkbox"/> Non-exempt, incomplete Logged in _____ by _____	<input type="checkbox"/> Needs folder <input type="checkbox"/> Verified on: _____ <input type="checkbox"/> Follow-up needed: __call __E-Mail __letter	<p><b>Manifest summary</b></p> <p>H. Total amount of infectious waste manifested _____ lbs.                  I. Amount of waste accounted for by return manifests _____ lbs.                  J. Total number of manifests not yet returned to generator _____</p> <p><input type="checkbox"/> IW data complete, ready to enter                  Log updated _____ by _____                  SHWIMS data entered _____ by _____                  IW data entered _____ by _____</p>
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**Part III - MEDICAL WASTE REDUCTION PROGRESS REPORT**

For all hospitals, clinics and nursing homes unless exempted from implementing medical waste reduction plans.

**K. Medical waste generation rate.** Calculate the rate using only one of the formulae below or your DNR-approved formula.

**Hospitals and Nursing Homes**

(1) Total from Line A (on reverse) \_\_\_\_\_ lbs.  
**F.** Number of Patient-days \_\_\_\_\_ Pt.-day  
**K.** Divide Line (1) by Line F \_\_\_\_\_ lbs./Pt.-day

**Dialysis Clinics**

(1) Total from Line A (on reverse) \_\_\_\_\_ lbs.  
**FD.** Number of Dialysis treatments \_\_\_\_\_ treatments  
**K.** Divide Line (1) by Line FD \_\_\_\_\_ lbs./trmt

**Clinics**

(1) Total from Line A (on reverse) \_\_\_\_\_ lbs.  
**G.** Number of treatment areas \_\_\_\_\_ treatment areas  
(2) Divide Line (1) by Line G \_\_\_\_\_ lbs./treatment area  
(3) Days in year 365 days  
**K.** Divide Line (2) by Line (3) \_\_\_\_\_ lbs./treatment area per day

**Facilities with DNR-approved formula**

**K.** Your formula calculates this rate \_\_\_\_\_ (attach your calculations)

**L.** Medical waste policy \_\_\_\_\_ Date \_\_\_\_\_  
Policy title \_\_\_\_\_  
**M.** Medical waste reduction plan \_\_\_\_\_ Date \_\_\_\_\_  
Plan title \_\_\_\_\_  
**N.** If you revised the plan this year, list revision date(s): \_\_\_\_\_ mm/dd/yyyy \_\_\_\_\_ mm/dd/yyyy

**O. Summary of medical waste reduction plan.** Briefly summarize what you will do over the next 5 years. Answer all questions in the instructions for Line O.

For DNR use only

Summary needed?	__yes__no
Summary attached?	__yes__no
Summary complete?	__yes__no
Progress report attached?	__yes__no
Progress report complete?	__yes__no

Report year for which DNR last received a complete summary of your plan

- Does that summary answer all questions in the instructions for line O?  
 Yes. Go to next question.  
 No. Attach a new summary which does answer all questions in the instructions.
- Has it been 5 years or more since you performed a waste audit, updated your plan, and sent DNR a complete summary?  
 Yes. Perform a waste audit, revise your plan and attach a new summary.  
 No. You don't need to submit a summary this year.
- If summary is attached, are the generator's name, facility ID number (from top of Part I) on the attachment?

**P. Description of progress.** Briefly describe what you did during the reporting year to implement your plan's goals and objectives. Attach one additional sheet which answers all the questions in the instructions for Line P.

**PART IV - CERTIFICATION**

Authorized Contact Name	<b>I certify that to the best of my knowledge, the above information and attachments are true and correct.</b>	
Mailing Address		Name of Director (Building manager or top administrator for this location)
City, State, Zip Code		Title
Telephone Number		Signature of Director <b>X</b> _____ Date Signed(mm/dd/yyyy) __/__/____
Electronic mail (Email) address		<input type="checkbox"/> Check here if form is submitted for a group of generators in the same location which manage their wastes together. Provide Part IV information, signature and date for each member of the group.
How do you prefer to be contacted if DNR has questions? <input type="checkbox"/> Telephone <input type="checkbox"/> Mail <input type="checkbox"/> Email		
DNR will send the invoice for the filing fee to the contact person above.		

**HOW TO SUBMIT FORM:** Copy signed form and attachments for your records. Submit original signed form and attachments to:  
Medical Waste Coordinator  
DNR Bureau of Waste Management  
P.O. Box 7921  
Madison, WI 53707-7921  
**Send no money now.** You will be billed for the \$55 filing fee.