

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 OB-GYN ASSOCIATES	Facility Identification No. (FID) 405181810	Report Year 2008
Generator Location DO EXEMPTION STATUS BOX FIRST		
Street Address of Generator 704 S WEBSTER AVE 3RD FLOOR		
City GREEN BAY	State WI	Zip Code 54301
County BROWN		
Owner OB-GYN ASSOCIATES		

Exemption Status Read instructions carefully

Check if exempt from Part II. You may be required to report under Part III.

Check if exempt from Part III. You may be required to report under Part II.

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?
 Yes No If not, why not? _____

Generator Type -Check all that apply

170 Hospital
 171 Nursing Home
 172 Physician office or clinic
 173 Dental office or clinic
 174 Veterinary office or clinic
 175 Clinical laboratory (freestanding)
 176 Dialysis clinic (freestanding)
 177 Other - Specify: _____

If you checked more than one, which one generated the most infectious waste? _____

Part II - Off-Site Treatment Report

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
Stericycle - per call to Maureen

Treatment facility address
14035 Leetsbir

City State Zip Code
Startevant WI 53177

First Treatment facility DNR Facility Identification Number (FID) _____

Infectious Waste Type -Check all that apply

W421 Sharps
 W422 Human tissue
 W423 Bulk blood and body fluids from humans
 W424 Microbiological laboratory waste
 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 _____

Infectious Waste On-site Activities -Total weights in reporting year Please round up to nearest pound.

A. Infectious waste generated on-site 1100 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 1100 lbs.

Second Treatment facility DNR Facility Identification Number (FID) _____

Report any additional treatment facilities on an attachment.

Manifest summary

H. Total amount of infectious waste manifested 1100 lbs.
I. Amount of waste accounted for by return manifests 1100 lbs.
J. Total number of manifests not yet returned to generator 0

FOR DNR USE ONLY - LEAVE BLANK

Date Stamp - Date form was received _____ Items missing or incomplete: _____ Follow-up done (date, action, initials): _____

R

Waste Manifest

Waste generated & transported

Needs FID Needs folder
 Verify exemption Verified on: _____
 Exempt
 Non-exempt, complete
 Non-exempt, incomplete
Logged in _____ by _____ Follow-up needed: call E-Mail letter

IW data complete, ready to enter
Log updated 3-3-09 by SH
SHWIMS data entered _____ by JG
IW data entered _____ by JG