

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 \$65 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: 2009

Generator Location DO EXEMPTION STATUS BOX FIRST → Exemption Status Read instructions carefully

Street Address of Generator: 704 S. WEBSTER AVE 3rd Floor
City: GREEN BAY State: WI Zip Code: 54301
County: BROWN
Owner: OB-GYN ASSOCIATES

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? _____

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 INC

Treatment facility address: 14036 LEETSBIK RD

City: STURTEVANT WI State: WI Zip Code: 53177

First Treatment facility DNR Facility Identification Number (FID): 252138260

Second off-site treatment facility name, from manifests: _____

Treatment facility address: _____

City: _____ State: _____ Zip Code: _____

Second Treatment facility DNR Facility Identification Number (FID): _____

Report any additional treatment facilities on an attachment.

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? _____

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

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

A. Infectious waste generated on-site 776 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 776 lbs.

Manifest summary

H. Total amount of infectious waste manifested 776 lbs.
I. Amount of waste accounted for by return manifests 776 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): _____



DONE Still need original e-mailed 6-8-2010 line P DONE

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 7-21-2010 by sg
SHWIMS data entered _____ by _____
IW data entered _____ by _____

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) 776 lbs.
 G. Number of treatment areas 24 treatment areas
 (2) Divide Line (1) by Line G 32.33 lbs./treatment area
 (3) Days in year 365 days
 K. Divide Line (2) by Line (3) 0.09 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.

Report year for which DNR last received a complete summary of your plan 2008

- 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?

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

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 Maureen Kowaleski
 Mailing Address 704 S. WEBSTER 3rd Floor
 City, State, Zip Code GREEN BAY WI 54301
 Telephone Number mkowaleski@obgyn.greenbay.com
 Electronic mail (Email) address phone 920-468-3444
 How do you prefer to be contacted if DNR has questions?
 Telephone Mail Email

I certify that to the best of my knowledge, the above information and attachments are true and correct.
 Name of Director (Building manager or top administrator for this location) Judy VICZIAN
 Title Practice Administrator
 Signature of Director X Judy Viczian Date Signed (mm/dd/yyyy) 07/13/2010
 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 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.

DNR will send the invoice for the filing fee to the contact person above.