

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.

445179460

Part I - Facility Information

Name of Infectious Waste Generator: Planned Parenthood of Wisconsin
 Facility Identification No. (FID): 1356515936
 Report Year: 2009
 Generator Location **DO EXEMPTION STATUS BOX FIRST** → Exemption Status Read instructions carefully

Street Address of Generator: 3800 North Callette Street
 City: Appleton State: WI Zip Code: 54912
 County: Ottawa

Owner: Planned Parenthood of Wisconsin

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 556.5 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 556 lbs.

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: Stenicycle
 Treatment facility address: 14035 Leetsville Rd
 City: Shrewsbury 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.

Manifest summary

- H. Total amount of infectious waste manifested 556.5 lbs.
- I. Amount of waste accounted for by return manifests 556.5 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): _____



-line 0 + original 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 8-20-2010 by sgg
 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) 555.5 lbs.
 G. Number of treatment areas 1 treatment areas
 (2) Divide Line (1) by Line G 555.5 lbs./treatment area
 (3) Days in year 365 days
 K. Divide Line (2) by Line (3) 1.52 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

Medical Waste policy 5.18.10

M. Medical waste reduction plan

Date
 Plan title

Medical Waste Reduction Plan 5.18.10

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 2009

- 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.

PPWI is new to reporting to Department of Natural Resources. Policy and plan are in draft form. Manifest audit is in process with comparison of amount of medical waste to patient load pens assessed. Additional training to take place if indicated.
OK new facility 8-26-2010

PART IV - CERTIFICATION

Authorized Contact Name
Katharine F. Burnett
 Mailing Address
302 W Jackson Street
 City, State, Zip Code
Milwaukee, WI 53202
 Telephone Number
(414) 289-3765
 Electronic mail (Email) address
Katharine.burnett@ppwi.org
 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)

Katharine F. Burnett

Title
Vice President of Patient Services

Signature of Director

X [Signature]

Date Signed (mm/dd/yyyy) 08/06/2010

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.

MEDICAL WASTE MANAGEMENT PROGRAM

PPWI's Medical Waste Reduction Plan

It is Planned Parenthood of Wisconsin's goal to reduce all waste generated from health care provision and business operations. All centers and departments are to assess their waste and limit as possible. Recycling bins are to be used appropriately. For PPWI's 3 abortion centers a Medical Waste Reduction Plan is required with the intent to reduce medical waste whenever possible.

A.Center Managers will review their Stericycle reports quarterly to ensure there is no increase weight in their monthly medical waste. If there is an increase noted Center Managers must:

- 1) Assess recent procedure changes that may have increase waste.
- 2) Assess change in staffing pattern and review who may be "red bagging" excessive amounts.
- 3) Create Improvement Plans to decrease amount of medical waste which should include:
 - i. Assessing medical waste. If it is necessary to identify if non-infectious wastes have been added to the "red bag", you may do so by opening the "red bag" according to the Wisconsin State law (section NR 526.07 (3)). But this must be done wearing appropriate PPE and using tools instead of hands to sort.
 - ii. Additional Staff Training.
 - iii. Ongoing monitoring of Stericycle monthly until target weight is maintained. Target weight is determined by looking at the lowest 3 months of medical waste weight.
- 4) Create a Medical Waste workgroup to review medical waste and ensure only those items necessary to be "red bagged" are.
 - i. Workgroup members – Clinical/OSHA Trainer, one Center Manager, two surgical assistants, one RN and one Regional Director with representation from all three abortion centers
 - ii. Meet monthly to establish policy, center medical waste audit, site specific goals, best practices and looking at alternatives to disposable items
 - iii. Train staff of policy during center staff meeting
 - iv. Meet semi-annually thereafter to ensure ongoing compliance
- 5) The Center Managers are required to ensure the policy and plan developed by the Medical Waste Workgroup are met. Progress reports to the Department of Natural Resources will be completed by the Vice President of Patient Services as required.