



20__ Annual Summary Report

For a Transporter or Self Transporter of Special Waste from Health Care Related Facilities
(Medical Waste)

Report Period: January 1 through December 31, each year
Due: **March 1 of each year**

Transporter Name: _____ Registration Number: _____

Part 1: Amount of untreated medical waste collected (in pounds) from Texas generators and transported to permitted facilities in Texas.		
Disposal Site Name/Address/City, State, Zip Code	Disposal Site Permit Number	Amount of Waste Deposited/Unloaded (lbs)
Name: _____ Address: _____ City, State, Zip Code: _____		
Name: _____ Address: _____ City, State, Zip Code: _____		
Name: _____ Address: _____ City, State, Zip Code: _____		
Name: _____ Address: _____ City, State, Zip Code: _____		
TOTAL		

Part 2: Amount of untreated medical waste collected (in pounds) from Texas generators and transported to out of state facilities.		
Disposal Site Name/Address/City, State, Zip Code	Disposal Site Permit Number	Amount of Waste Deposited/Unloaded (lbs)
Name: _____ Address: _____ City, State, Zip Code: _____		
Name: _____ Address: _____ City, State, Zip Code: _____		
Name: _____ Address: _____ City, State, Zip Code: _____		
Name: _____ Address: _____ City, State, Zip Code: _____		
TOTAL		

-photocopy as needed-

Part 3: Amount of untreated medical waste delivered (in pounds) to facilities in Texas from out of state generators.

Disposal Site Name/Address/City, State, Zip Code	Disposal Site Permit Number	Amount of Waste Deposited/Unloaded (lbs)
Name: _____ Address: _____ City, State, Zip Code: _____		
Name: _____ Address: _____ City, State, Zip Code: _____		
Name: _____ Address: _____ City, State, Zip Code: _____		
Name: _____ Address: _____ City, State, Zip Code: _____		
TOTAL		

Please provide any changes in the following registrant information. Administrative changes must be made on the TCEQ Core Data Form (TCEQ 10400).

Street Address: _____ Mailing Address: _____
 City, State, Zip Code: _____ City, State, Zip Code: _____
 Telephone Number: () _____
 Fax Number: () _____
 Contact Person: _____ Telephone Number: () _____

Certification Statement:

I certify that the above information is true and correct to the best of my knowledge, and I will abide by all Texas Commission on Environmental Quality rules.

Signature: _____ Date: _____
 Print Name: _____

If you have questions on how to fill out this form or about the Medical Waste transporter registration program, please contact us at 512/239-6413.

Individuals are entitled to request and review their personal information that the agency has gathered on its forms. They may also have any errors in their information corrected. To review such information, contact us at 512/239-3282.

We appreciate your cooperation in completing this report which is required by the Title 30 Texas Administrative Code Section 330.9(l)(5). Return to:

Texas Commission on Environmental Quality
 Registration and Reporting Section, MC 129
 P.O. Box 13087
 Austin, Texas 78711-3087
 Internet address: www.tceq.com