FORM - II

(See rule10)

APPLICATION FOR AUTHORISATION OR RENEWAL OF AUTHORISATION

(To be submitted by occupier of health care facility or common bio-medical waste treatment facility)

To

The Prescribed Authority
(Name of the State or UT Administration)
Address.

1. Particulars of Applicant:

(i) Name of the Applicant:
(In block letters & in full)

(ii) Name of the health care facility (HCF) or common bio-medical waste treatment facility (CBWTF) :

(iii) Address for correspondence:

(iv) Tele No., Fax No.:

(v) Email:

(vi) Website Address:

2. Activity for which authorisation is sought:

Activity	Please tick
Generation, segregation	
Collection,	
Storage	
packaging	
Reception	
Transportation	
Treatment or processing or conversion	
Recycling	
Disposal or destruction	
use	
offering for sale, transfer	
Any other form of handling	

3. Application for □ fresh or □ renewal of authorisation (please tick whatever is applicable):

(i) Applied for CTO/CTE Yes/No

(ii) In case of renewal previous authorisation number and date:

(iii) Status of Consents:

(a) under the Water (Prevention and Control of Pollution) Act, 1974

(b) under the Air (Prevention and Control of Pollution) Act, 1981:
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4. (i) Address of the health care facility (HCF) or common bio-medical waste treatment facility (CBWTF):

(ii) GPS coordinates of health care facility (HCF) or common bio-medical waste treatment facility (CBWTF):

5. Details of health care facility (HCF) or common bio-medical waste treatment facility (CBWTF):

(i) Number of beds of HCF:
(ii) Number of patients treated per month by HCF:
(iii) Number healthcare facilities covered by CBMWTF: _______
(iv) No of beds covered by CBMWTF: _______
(v) Installed treatment and disposal capacity of CBMWTF:________ Kg per day
(vi) Quantity of biomedical waste treated or disposed by CBMWTF:______ Kg/ day
(vii) Area or distance covered by CBMWTF:________________
(pl. attach map a map with GPS locations of CBMWTF and area of coverage)
(viii) Quantity of Biomedical waste handled, treated or disposed:

<table>
<tr><th>Category</th><th>Type of Waste</th><th>Quantity Generated or Collected, kg/day</th><th>Method of Treatment and Disposal (Refer Schedule-I)</th></tr>
<tr><td>(1)</td><td>(2)</td><td>(3)</td><td>(4)</td></tr>
<tr><td rowspan="8">Yellow</td><td>(a) Human Anatomical Waste:</td><td rowspan="8"></td><td rowspan="8"></td></tr>
<tr><td>(b)Animal Anatomical Waste :</td></tr>
<tr><td>(c) Soiled Waste:</td></tr>
<tr><td>(d) Expired or Discarded Medicines:</td></tr>
<tr><td>(e) Chemical Solid Waste:</td></tr>
<tr><td>(f) Chemical Liquid Waste :</td></tr>
<tr><td>(g) Discarded linen, mattresses, beddings contaminated with blood or body fluid.</td></tr>
<tr><td>(h) Microbiology, Biotechnology and other clinical laboratory waste:</td></tr>
<tr><td>Red</td><td>Contaminated Waste (Recyclable)</td><td></td><td></td></tr>
<tr><td>White (Translucent)</td><td>Waste sharps including Metals:</td><td></td><td></td></tr>
<tr><td rowspan="2">Blue</td><td>Glassware:</td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>Metallic Body Implants</td></tr>
</table>

6. Brief description of arrangements for handling of biomedical waste (attach details):

(i) Mode of transportation (if any) of bio-medical waste:

(ii) Details of treatment equipment (please give details such as the number, type & capacity of each unit)

	No of units	Capacity of each unit
Incinerators :		
Plasma Pyrolysis:		
Autoclaves:		
Microwave:		
Hydroclave:		
Shredder:		
Needle tip cutter or destroyer		
Sharps encapsulation or concrete pit:		
Deep burial pits:		
Chemical disinfection:		
Any other treatment equipment:		

7. Contingency plan of common bio-medical waste treatment facility (CBWTF)(attach documents):
8. Details of directions or notices or legal actions if any during the period of earlier authorisation

9. Declaration

I do hereby declare that the statements made and information given above are true to the best of my knowledge and belief and that I have not concealed any information.

I do also hereby undertake to provide any further information sought by the prescribed authority in relation to these rules and to fulfill any conditions stipulated by the prescribed authority.

Date : Signature of the Applicant

Place : Designation of the Applicant