

REVERSE DISTRIBUTED PHARMACEUTICALS MANAGEMENT PLAN

To fill out this document electronically fill out the management plan, "save as" and email back to PHE@co.washington.mn.us. Alternatively you may print, fill out by hand and mail to the address above.

A. Hazardous Waste Generator Information

Company:

Address:

Phone: Fax:

EMAIL:

HWID Number: MN__ - ____ - ____ - ____

B. Hazardous Waste Information

1. Hazardous Waste Name:

2. Hazardous Waste Code(s):

3. Generation Process. Describe how the waste is generated:

4. Generation amount (gallons or pounds annually).

C. Storage Information. List type of container(s) and storage location(s).

D. Reverse Distributor Information.

Name:

Address:

Phone: EMAIL:

MN Pharmacy Board license number:

E. Final Destination Waste Treatment/Disposal Information.

End Facility:

Address:

Waste Management Method:

TSDF EPA ID number (if applicable): _____ - _____ - _____ - _____

NOTE: For multiple End Facilities or Management Methods, attach additional sheets as necessary.

F. Certification

I hereby apply to amend my Washington County Hazardous Waste Generator License with the above additions or changes to my License subject to all conditions and provisions of MN Rules Chap. 7045 and the Washington County Hazardous Waste Management Ordinance.

- 1. I hereby certify that all discarded pharmaceuticals sent to the reverse distributor will be managed in accordance with the Minnesota Pollution Control Agency (MPCA) Program Management Decision (PMD) May 6, 2011 memo regarding Undispensed Discarded Pharmaceuticals and that all required documentation will be maintained onsite and readily available.*
- 2. I hereby certify that I have personally examined and am familiar with the information submitted in this and all accompanying documents and that based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate and complete.*
- 3. I hereby certify that I am aware that unless otherwise approved by the Department hazardous wastes generated by me or my company must be removed by a licensed hazardous waste transporter and managed by a permitted treatment, storage and disposal facility prior to moving or going out of business.*

Print NAME:

Print TITLE:

SIGNATURE: DATE:

EMAIL:

<p>COUNTY USE ONLY: Plan Approved or Disapproved (circle one) by: HW Inspector (initials) _____ Date: _____</p> <p>Inventory Key Code: _____ MP updated: _____ Notes: _____</p>
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