Biomedical Waste Service Location Setup Form

Name of Service Location: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Title: _____

Phone: _____ Fax: _____

Email for manifest notifications: _____

Billing: **Invoices will be sent via email only! Please provide AP contact & email below.**

Contact Name: _____ Phone: _____

Email for invoices: _____

Pickup Frequency: _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Office Hours:					
Lunch Hours:					

Does your facility specialize in any of these highly infectious diseases? (Check all that apply):

COVID___ HIV___ HBV___ HCV___ Other (please specify) _____

How soon would you like to start service? _____

Comments: Indicate here if you would like 30 gallon size or 96 gallon size container(s) and how many

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