



New York State Department of Environmental Conservation  
Division of Materials Management

Revised 2014

**Medical Waste Tracking Form**

**Emergency Response Number:**

**GENERATOR**

**INSTRUCTIONS**

**TRANSPORTER**

**DESTINATION**

1. Generator's Name and Mailing Address: \_\_\_\_\_  
2. Tracking Form Number: \_\_\_\_\_

3. Telephone number: \_\_\_\_\_  
4. State Permit or ID No.: \_\_\_\_\_

5. Transporter's Name and Mailing Address: \_\_\_\_\_  
6. Telephone Number: \_\_\_\_\_

7. State Transporter or ID No. \_\_\_\_\_

8. Destination Facility Name and Address: \_\_\_\_\_  
9. Telephone Number: \_\_\_\_\_

10. State Permit or ID No. \_\_\_\_\_

11. USDOT Shipping Name:	12. Total No. Containers	13. Total Weight or volume
<input type="checkbox"/> HM a. <input checked="" type="checkbox"/> Regulated Medical Waste, 6.2, UN3291, PGII		
b.		

14. Special Handling Instructions: \_\_\_\_\_

14.(a) Additional Information \_\_\_\_\_

15. Generator's Certification:  
I hereby declare, on behalf of the generator \_\_\_\_\_  
that the contents of this consignment are fully and accurately described above by proper shipping name and are classified, packed, marked, and labeled, and are in all respects in proper condition for transport by highway according to applicable international and national government regulations and state laws and regulations.

Print/Type Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**Instructions for completing the medical waste tracking form:**  
Copy 1 - GENERATOR COPY: Mailed by Destination Facility to Generator  
Copy 2 - DESTINATION FACILITY COPY: Retained by Destination Facility  
Copy 3 - TRANSPORTER COPY: Retained by Transporter  
Copy 4 - GENERATOR COPY: Retained by Generator

1. This multi-copy (4 page) shipping document must accompany each shipment of regulated medical waste generated in New York State.  
2. Items numbered 1-14 must be completed before the generator can sign the certification. Items 4,7,10 & 19 are optional unless required by the particular state. Item 22 must be completed by the destination facility.

16. Transporter 1 (Certification of Receipt of Waste as described in items 11, 12 & 13)

Print/Type Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

17. Transporter 2 or Intermediate Handler (Name and Address) \_\_\_\_\_

18. Telephone Number \_\_\_\_\_

19. State Transporter Permit or ID No. \_\_\_\_\_

20. Transporter 2 or Intermediate Handler (Certification of Receipt of Waste as described in items 11, 12 & 13)

Print/Type Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

21. New Tracking Form Number (for consolidated or remanifested waste) \_\_\_\_\_

22. Destination Facility (Certificate of Receipt of Medical Waste as described in items 11, 12 & 13)  
 Received in accordance with items 11, 12 & 13

Print/Type Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(If other than destination facility, indicate address, phone, and permit or ID no. in box 14)

23. Discrepancy Box (Any discrepancies should be noted by item number and initials)