



# REGULATED MEDICAL WASTE MANIFEST

Regulated Medical Waste 6.2, UN3291, PG II

TCEQ • P.O. Box 13087 • Austin, TX 78711-3087

CODE AREA

<b>GENERATOR</b>	COMPANY NAME		TELEPHONE NUMBER	
	ADDRESS			
	<i>I certify that the information provided is true and correct, and that the generated materials are properly classified, described, packaged, labeled/placarded; and are in proper condition for transportation according to the applicable regulations of the U.S. Department of Transportation.</i>			
	NAME OF COMPANY REPRESENTATIVE (PLEASE PRINT)		SIGNATURE OF REPRESENTATIVE      DATE	
<b>PRIMARY TRANSPORTER</b>	NAME OF PERSON COLLECTING, TRANSPORTING OR UNLOADING WASTE			INITIALS
	COMPANY NAME		TELEPHONE NUMBER	
	ADDRESS		DATE MEDICAL WASTE COLLECTED	
	TCEQ REGISTRATION NUMBER	NUMBER OF CONTAINERS COLLECTED	TOTAL WEIGHT OF CONTAINERS	
	<i>I certify that the information provided is true and correct, and that only <u>untreated</u> medical waste are contained in this load. I am aware that falsification of this manifest may result in forfeiture of my transporter's registration and/or the privilege of utilizing State-authorized facility.</i>			
	NAME OF COMPANY REPRESENTATIVE (PLEASE PRINT)		SIGNATURE OF REPRESENTATIVE      DATE	
<b>SECONDARY TRANSPORTER</b>	NAME OF PERSON COLLECTING, TRANSPORTING OR UNLOADING WASTE			INITIALS
	COMPANY NAME		TELEPHONE NUMBER	
	ADDRESS		DATE MEDICAL WASTE COLLECTED	
	TCEQ REGISTRATION NUMBER	NUMBER OF CONTAINERS COLLECTED	TOTAL WEIGHT OF CONTAINERS	
	<i>I certify that the information provided is true and correct, and that only <u>untreated</u> medical waste are contained in this load. I am aware that falsification of this manifest may result in forfeiture of my transporter's registration and/or the privilege of utilizing State-authorized facility.</i>			
	NAME OF COMPANY REPRESENTATIVE (PLEASE PRINT)		SIGNATURE OF REPRESENTATIVE      DATE	
<b>TREATMENT FACILITY</b>	COMPANY NAME		TELEPHONE NUMBER	
	ADDRESS			
	TCEQ REGISTRATION NUMBER	DATE WASTE DEPOSITED/UNLOADED	TOTAL WEIGHT DEPOSITED/UNLOADED	
	DISCREPANCY INDICATION SPACE			
	<i>I certify that the information provided is true and correct, and that only <u>untreated</u> medical waste are contained in this load. I am aware that falsification of this manifest may result in forfeiture of my transporter's registration and/or the privilege of utilizing State-authorized facility.</i>			
	NAME OF COMPANY REPRESENTATIVE (PLEASE PRINT)		SIGNATURE OF REPRESENTATIVE      DATE	