CREDIT CARD/CHECK CARD VERIFICATION AUTHORIZATION FORM

Requesting Company: _____Requesting Date: _____

Credit Card Number: _____Expiration Date: _____

Printed Name: _____Phone Number: _____

Card Holder's Signature: _____(Required)

Total Charged: _____

Permit Numbers: _____(If known) or

Permit Address: _____

Service Type Requested (i.e.: repair permit, re-inspection fee, swimming pool permit, well permit, etc.):
_____

Applicant(s) Name on Permit: _____

Cardholder Billing Address: _____

_____

_____

Comments: _____

The credit card will be charged upon receipt unless otherwise noted in the comments section. The Orange County Health Dept. hereby acknowledges that the signature above denotes authorization to charge the referenced account for payment for this (these) specific services(s). Charges to the above account will not exceed the agreed upon total. The Orange County Health Dept. also acknowledges that additional charges will not be made unless additional written authorization is received and specified on this or a subsequent credit card verification/authorization form.

If you have any questions regarding these charges, please feel free to contact our office.

DH use only: Check No. _____ Check Amount _____

Date Received _____ Receipt No. _____

Permit No. _____ Date Issued _____

Department of Health

Application for Biomedical Waste Generator Permit/Exemption

A biomedical waste generator is required to apply for an annual biomedical waste permit and abide by the requirements of Chapter 64E-16, Florida Administrative Code (F.A.C.). The initial permit fee is $85.00. Permits expire September 30 of each year. The permit fee for renewal applications received by October 1 is $85.00. The permit fee for renewal applications received after October 1 is $105.00. State-owned and operated facilities are exempt from the permit fee. Submit the following information on this form to your local Department of Health Biomedical Waste Coordinator.

FOR CURRENTLY PERMITTED GENERATORS ONLY: A currently permitted biomedical waste generator, that produces **less than 25 pounds of biomedical waste** in each 30 day period, may claim an exemption from the fee and permitting requirements only of Chapter 64E-16, F.A.C. **A currently permitted biomedical waste generator applying for exemption from permitting must submit documentation from the previous 12 months showing the biomedical waste generated in each 30 day period during those 12 months was less than 25 lbs. Documentation must include the amount of waste generated in each 30 day period for the previous 12 months and may be in the form of a monthly log or receipts.**

1. **Application for (choose one):** _____ **Permit** _____ **Exemption (attach appropriate documentation)**
   (Applicant must be a legal entity, i.e.: individual, partnership, corporation, association, or public body)

2. Facility Name: _____

3. Facility Address: _____
   Street City State Zip Code

4. Contact Person: _____ Telephone: ( ) _____

5. Name of Facility Owner: _____

6. Mailing Address of Facility Owner: _____
   Street City State Zip Code

7. Business Phone: ( ) _____ 24-Hour Emergency Phone: ( ) _____

8. Name of Property Owner: _____

9. Mailing Address of Property Owner: _____
   Street City State Zip Code

10. Type of Waste Generated: _____ Sharps _____ Non-sharps

11. Method of Removal (Check One): _____1. By applicant, to where: _____
    _____2. By transporter, company name: _____

12. Maximum weight of biomedical waste generated during any 30-day period: _____ lbs.

13. Branch Offices: _____ Yes _____ No If yes, attach sheet with complete name, address and phone number of branch office(s).

Check Type of Facility:

	01. Hospital		07. Dentist		13. Surgical Center/Walk-in Clinic
	02. Funeral Home		08. Podiatrist		14. Blood Banks
	03. Dialysis Clinic		09. Osteopath		
	04. Nursing Home		10. Home Health		16. Abortion Clinics
	05. Veterinarian		11. State Laboratory/Clinic		17. Other (specify)
	06. Medical Doctor		12. Clinical Laboratory		18. Tattoo/Body Piercing

The undersigned owner/owner's representative hereby agrees to operate the biomedical waste generating facility described in this application in accordance with the requirements of Section 381.0098, Florida Statutes, and Chapter 64E-16, F.A.C. The information contained in this application, which serves as a basis for permitting or exemption, is true and correct. I understand that any misrepresentation of the facts in this application, or failure to comply with sanitary standards, is grounds for denial, administrative fine or revocation of the biomedical waste permit or exemption. Biomedical waste shall be handled within the facility in accordance with the generator's written operating plan. Operating plan must be in compliance with 64E-16, F.A.C.

_____ _____ _____
Signature of Authorized Representative Name of Authorized Representative (print or type) Date

BIOMEDICAL WASTE PERMIT REQUIREMENTS

This sheet must be completed for all new facilities. If this is a change of ownership or location, you must also complete this form. Biomedical Waste permits are non-transferable. An inspection must be performed prior to opening of the facility.

DATE: _____ **PROPOSED # OF STAFF: _____**

FACILITY NAME: _____

FACILITY ADDRESS:_____

BILLING ADDRESS: _____

PERSON TO CONTACT: _____ PHONE #: _____

EMAIL ADDRESS: _____ (optional)

Part I

_____ **Total amount due is $223.00 ($53.00 for the initial plan review and $170.00 for the permit).**

_____ **Utility bill showing sewer charges or letter of sewer connection provided. If facility is on septic, please answer next line.**

_____ **Facility is on septic. Must fill out Existing System Verification or modify existing annual operating permit if applicable. (Additional fees will apply for septic)**

_____ **Floor plans of facility provided and drawn to scale. Scale must be shown on the floor plan.**

_____ **Is facility on city water or well? (Please circle one) If on well, please supply permit.**

_____ **Complete biomedical waste application (A permit fee will apply. If on septic or well, please do not submit biomedical waste application at this time. You will be notified once septic or well has been approved).**

Part II The following are required at the time of inspection:

_____ **Red bags and sharps container in every room that handles sharps and non-sharp biomedical waste.**

_____ **Biomedical Waste Operating Plan and list of Biomedical Waste Transporter Companies**

_____ **Provide documentation of training of employees on biomedical waste**

_____ **64E-16 Florida Administrative Code (F.A.C.)**

_____ **Service Agreement from Biomedical Waste transporter**

_____ _____

Signature, Owner / Owner's Representative Date

Updated: April 2022

Florida Department of Health
in Orange County • Environmental Health
1001 Executive Center Drive #200 Orlando, FL 32803
PHONE: 407/858-1497 • FAX: 407/228-1467
FloridaHealth.gov

ORANGE COUNTY HEALTH DEPARTMENT PLANS REVIEW ROUTING SHEET

DATE: _____ _____ **(Official Use Only) PLANS ROUTING NUMBER: _____**

PAYMENT TYPE: _____ _____ **AMOUNT: $_____ ____** **CHECK NUMBER: _____**

Please note, the fee for plan review is $53 per hour. If your plan review requires additional time or requires revisions, you will be charged an additional $53 per hour before approval. Please sign below to acknowledge your understanding and acceptance of these conditions. By signing below, you are also certifying that the information provided is true and correct.

SIGNATURE:_____ **DATE:_____**

FACILITY NAME:_____

FACILITY ADDRESS:_____

BILLING ADDRESS:_____

TYPE OF FACILITY: _____ **NUMBER OF EMPLOYEES: _____**

NUMBER OF CLIENTS, STUDENTS, CUSTOMERS OR SEATING CAPACITY: _____

METHOD OF SEWAGE DISPOSAL:_____ _____ **WATER SUPPLY:_____**

PERSON TO CONTACT:_____ _____ **PHONE #:_____**

COMMENTS:_____

FOR OFFICE USE ONLY

UTILITY REVIEWER:_____ **DATE:_____**

REMARKS: _____ **APPROVAL STAMP**

_____

_____

_____

_____ **SIGNATURE:_____**

FACILITY REVIEWER:_____ **DATE:_____ _____**

REMARKS:_____ _____

_____ _____

_____ **SIGNATURE:_____ _____**

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