|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **FA** |  | | | **PR** | |  | |
|  | | | | | | | |
| **Event Information** | | | | | | | |
| **Event Name:** | |  | | | | | |
|  | |  | | | | | |
| **Address:** | |  | | | | | |
|  | |  | | | | | |
| **Phone:** | |  | | | | | |
| **Contact Person:** | |  | | | | | |
| **Event Type:** | | Vaccine Clinic | Blood Drive | | Stand Down Event | | Health Fair |
| Other: | | | | | |
| **Event Date(s):** | |  | | | | | |
| **Participating Facility Information** | | | | | | | |
| **Facility Name:** | |  | | | | | |
|  | |  | | | | | |
| **Address:** | |  | | | | | |
|  | |  | | | | | |
| **Phone:** | |  | | | | | |
| **Contact Person:** | |  | | | | | |
| **Offsite Event Filing Fee Information** | | | | | | | |
| The notification fee for temporary offsite events is $126.00. Your facility will receive a separate bill for the notification.  **Do not remit payment with your notification form**. | | | | | | | |
| **Signature** | | | | | | | |
| Self-Declaration: I certify that the above information is complete & correct to the best of my knowledge.  Signature: Date: | | | | | | | |

**Instructions for applicant:**

* Fill out the white portions of the notification form. The gray portions will be filled in by Environmental Management Department staff.
* Email the completed form to [medicalwaste@saccounty.gov](mailto:medicalwaste@saccounty.gov), or fax to (916) 875-8513 Attn: Medical Waste Program, or mail to:

Environmental Management Department

Medical Waste Program

11080 White Rock Road Ste 200

Rancho Cordova, CA 95670

* Do not remit payment with your application, your facility will be billed separately.
* Keep a copy of the completed notification form(s) for your records and make them available for review by regulatory personnel during your facility’s routine inspections.
* For assistance in filling out your notification form, contact a Medical Waste Program staff person at (916) 875-8440.