MEDICAL WASTE TRACKING & SHIPPING DOCUMENT

GENERATOR

East Coast Worldwide
8833 Perimeter Park Blvd
Ste 501
Jacksonville , FL 32216

Tracking ID #: 2929621
Customer ID #: 3322557002
Telephone #: (904) 685-6516
State ID #:

Emergency Spill Response:
CHEMTREC (1-800-424-9300)
CCN 851124

Description of Waste	Quantity	Weight (lbs) or Volume (gal)	Transfer
UN 3291 Regulated Medical Waste, n.o.s.,6.2, pg II			
23gal BIO Corrugated Box	1	23	Yes

Generator's Certification This is to certify that the above materials are properly classified, described, packaged, marked and labeled, and are in proper condition for transportation according to the applicable regulations of the Department of Transportation.

Print Name: Jordan Dzialoski Signature: Date: Oct 7, 2024

TRANSPORTER

Collection Transporter:
Trilogy MedWaste SE- Jacksonville
5502 Shawland Rd
Jacksonville, FL 32254-1672

Telephone # : (888) 763-3927
State Permit # : FDOH # 7817
Transport Date: Oct 7, 2024
Print Name: James Mathis
Signature:

Transporter's Certification:
I certify, under penalty of criminal and/or civil prosecution for making or submission of false statements, representations, or omissions that I have read, understood, and will comply with the applicable State and Federal Regulations.

Transporter #1 - Name and Address:	Transporter #2 - Name and Address:	Transporter #3 - Name and Address:
Telephone #: State Permit #: Transport Date: Print Name: Signature:	Telephone #: State Permit #: Transport Date: Print Name: Signature:	Telephone #: State Permit #: Transport Date: Print Name: Signature:

TRANSFER

Transfer Station #1 - Name and Address:	Transfer Station #2 - Name and Address:	Transfer Station #3 - Name and Address:
Telephone #: State Permit ID #: Received Date: Consolidation Tracking ID#: Transfer Date:	Telephone #: State Permit ID #: Received Date: Consolidation Tracking ID#: Transfer Date:	Telephone #: State Permit ID #: Received Date: Consolidation Tracking: ID#: Transfer Date:

DESTINATION

Destination Facility #1 - Name and Address:	Destination Facility #2 - Name and Address:	Destination Facility #3 - Name and Address:
Telephone #: State Permit ID #: Consolidation Tracking ID#:	Telephone #: State Permit ID #: Consolidation Tracking ID#:	Telephone #: State Permit ID #: Consolidation Tracking ID#:
Certification of Receipt Print Name: Date: Signature:	**Certification of Receipt** Print Name: Date: Signature:	**Certification of Receipt** Print Name: Date: Signature:

I certify that I have been authorized to accept untreated medical wastes and that I have received the above indicated wastes in accordance with the requirements outlined in that authorization.

Certification of Destruction	Certification of Destruction	Certification of Destruction
Print Name: Date: Signature:	Print Name: Date: Signature:	Print Name : Date: Signature:

On behalf of the treatment facility, this is to certify that all medical wastes have been treated in accordance with all applicable regulations.

Discrepancy: