




GENERATOR	East Coast Worldwide 8833 Perimeter Park Blvd Ste 501 Jacksonville , FL 32216		Tracking ID #: 3101426 Customer ID #: 3322557002 Telephone #: (904) 685-6516 State ID #:		 Emergency Spill Response: CHEMTREC (1-800-424-9300) CCN 851124	
	Description of Waste UN 3291 Regulated Medical Waste, n.o.s.,6.2, pg II		Quantity	Weight (lbs) or Volume (gal)		Transfer
	23gal BIO Corrugated Box		1	23		Yes
GENERATOR	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: Julia Lemeshko		Signature: 		Date: Jan 9, 2025	
TRANSPORTER	Collection Transporter: Trilogy MedWaste SE- Jacksonville 5502 Shawland Rd Jacksonville, FL 32254-1672		Telephone # : (888) 763-3927 State Permit # : FDOH # 7817 Transport Date: Jan 9, 2025 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:	
TRANSFER	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 Station #1 - Name and Address:		Transfer Station #2 - Name and Address:		Transfer Station #3 - Name and Address:	
DESTINATION	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 Facility #1 - Name and Address:		Destination Facility #2 - Name and Address:		Destination Facility #3 - Name and Address:	
DESTINATION	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 Print Name: Date: Signature:		Certification of Destruction Print Name: Date: Signature:		Certification of Destruction 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:						