**Form - IV**

**(See rule 13)**

**ANNUAL REPORT**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sl.no** | **Particulars** | | | | |
| 1 | **Particulars of the Occupier** |  | | | |
| (i) Name of the authorised person (occupier or operator of facility) |  | | | |
| (ii) Name of HCF or CBMWTF |  | | | |
| (iii) Address for Correspondence |  | | | |
| (iv) Address of Facility |  | | | |
| (v)Tel. No, Fax. No |  | | | |
| (vi) E-mail ID |  | | | |
| (vii) URL of Website |  | | | |
| (viii) GPS coordinates of HCF or CBMWTF |  | | | |
| (ix) Ownership of HCF or CBMWTF | (State Government or Private or Semi Govt. or any other) | | | |
| (x). Status of Authorisation under the Bio-Medical Waste (Management and Handling) Rules | Authorisation No.:  valid up to | | | |
| (xi). Status of Consents under Water Act and Air Act | Valid up to: | | | |
| 2 | Type of Health Care Facility | No. of Beds:….. | | | |
| (i) Bedded Hospital |  | | | |
| (ii) Non-bedded hospital(Clinic or Blood Bank or Clinical Laboratory or Research Institute or Veterinary Hospital or any other) |  | | | |
| (iii) Bed Capacity |  | | | |
| (iv) average occupancy rate per month; (1) IPD :-  (2) OPD:- |  | | | |
| (iv) License number and its date of expiry |  | | | |
| 3 | **Details of CBMWTF** |  | | | |
| (i) Number healthcare facilities covered by CBMWTF |  | | | |
| (ii) No of beds covered by CBMWTF |  | | | |
| (iii) Installed treatment and disposal capacity of CBMWTF: |  | | | |
| (iv) Quantity of biomedical waste treated or disposed by CBMWTF |  | | | |
| 4 | Quantity of waste generated or disposed in Kg per annum (on monthly average basis) | Yellow Category | | | |
| Red Category | | | |
| White | | | |
| Blue Category | | | |
| General Solid waste | | | |
| **5** | **Details of the Storage, treatment, transportation, processing and Disposal Facility** | | | | |
| (i) Details of the on-site storage facility | Size |  | | |
| Capacity |  | | |
| Provision of on-site storage (cold storage or any other provision) |  | | |
| (ii) Details of the treatment or disposal facilities | Type of treatment/ equipment | No of  Unit’s | Capacity  Kg/day | Quantity  Treated/disposed in kg/yr |
| Incinerators |  |  |  |
| Plasma Pyrolysis |  |  |  |
| Autoclaves |  |  |  |
| Microwave |  |  |  |
| Hydroclave |  |  |  |
| Shredder |  |  |  |
| Needle tip cutter or destroyer |  |  |  |
| Sharps /encapsulation or concrete pit |  |  |  |
| Deep burial pits: |  |  |  |
| Chemical disinfection |  |  |  |
| Any other treatment /equipment |  |  |  |
| (iii) Quantity of recyclable wastes sold to authorized recyclers after treatment in kg per annum. | Red Category (like plastic, glass etc.) |  | | |
| (iv) No of vehicles used for collection and transportation of biomedical waste |  | | | |
| (v) Details of incineration ash and ETP sludge generated and disposed during the treatment of wastes in Kg per annum |  | Quantity generated | Where  disposed | |
| Incineration |  |  | |
| Ash |  |  | |
| ETP Sludge |  |  | |
|  | (vi) Name of the Common Bio- Medical Waste Treatment Facility Operator through which wastes are disposed of |  | | | |
| (vii) List of member HCF not handed over bio-medical waste. |  | | | |
| 6 | **Do you have bio-medical waste**  **management committee? If yes, attach minutes of the meetings held during the reporting period** |  | | | |
| 7 | **Details trainings conducted on BMW** | | | | |
|  | (i) Number of trainings conducted on BMW Management. |  | | | |
|  | (ii) number of personnel trained |  | | | |
|  | (iii) number of personnel trained at the time of induction |  | | | |
|  | (iv) number of personnel not  undergone any training so far |  | | | |
|  | (v) whether standard manual for  training is available? |  | | | |
|  | (vi)( any other information) |  | | | |
| 8 | Details of the accident occurred  during the year |  | | | |
|  | (i) Number of Accidents occurred |  | | | |
|  | (ii) Number of the persons affected |  | | | |
|  | (iii) Remedial Action taken (Please attach details if any) |  | | | |
|  | (iv) Any Fatality occurred, details. |  | | | |
| 9 | Are you meeting the standards of air Pollution from the incinerator? How many times in last year could not met the standards? |  | | | |
|  | Details of Continuous online emission monitoring systems installed |  | | | |
| 10 | Liquid waste generated and treatment methods in place. How many times you have not met the standards in a year? |  | | | |
| 11 | Is the disinfection method or  sterilization meeting the log 4standards? How many times you have not met the standards in a year? |  | | | |
| 12 | Any other relevant information | (Air Pollution Control Devices attached with the  Incinerator) | | | |
| Certified that the above report is for the period from | |  | | | |

(Name and Signature of the Head of the Institution)

Date:

Place