ACT WorkCover

APPLICATION FOR A LICENCE / PERMIT TO

TRANSPORT CLINICAL WASTE

ACT Clinical Waste Act 1990

ACT Government

Send to: ACT WorkCover
GPO Box 224
CIVIC SQUARE ACT 2608

Ph: 02 6205 0200
Fax: 02 6205 0336

This application is to be accompanied by the payment of a fee of $_____

Name of Applicant: _____
(Name of firm or person wishing to carry the waste.)

Trading Name: _____

Postal Address: _____

_____ Post Code _____

Telephone No _____ Fax No _____

Premises at which vehicle is to be normally kept _____

_____

Description of Clinical Waste to be carried**.**

- ☐ Infectious/Potentially Infectious;
- ☐ Cytoxic;
- ☐ Laboratory Chemicals & Solvents
- ☐ Pharmaceutical Substances & Residues

Method of Collection/Containerisation Proposed; _____

_____

On board securing method proposed _____

Description of Vehicle to carry Waste**.**

Make _____ Model _____ Registration No._____

Engine No _____ Chassis No_____ Carrying Capacity _____

Date vehicle available for Inspection: ___ / ___ / ___

SIGNATURE by person authorised for and on behalf of the Applicant/Company: _____ Date ___ / ___ / ___

OFFICE USE ONLY

Approved / Not approved

Insurer: _____ Amount insured: $_____

Policy No.: _____ Expiry Date: ___ / ___ / ___

Inspector: _____ Date ___ / ___ / ___