Sections to be completed by patient

Patient's Details	
Patients Name & Address (Including postcode)	
Patient's Telephone Number	
Property Type	House, low rise flat, other (Circle as appropriate)
Pick up point	Side gate/ front door/ please knock/ Other (Circle as appropriate)

Signed (resident)..... Date.....

Sections to be completed by a Healthcare professional – Strictly Confidential

1	Does a Health care professional administer (please circle) YES NO **If Yes - please note that it is the responsibility of Healthcare professional to dispose of this waste**				
2	Does the patient require Sharps box(s) to be supplied by contractor (please circle) YES NO If yes, please circle the size of Sharps box required 1 Litre 4 Litre 7 Litre				
3.	Does the patient require clinical waste bags to be supplied YES NO If yes, please provide quantity needed _____				
Details of waste to be collected					
4	**Sharps box**	Size (please circle)	1 Litre	4 Litre	7 Litre
5	Frequency of collection:	(Please circle)	Weekly	Fortnightly	Other – (specify)
6	**Clinical Waste bags**	Please specify quantity to be collected			
7	Frequency of collection:	(Please circle)	Weekly	Fortnightly	Other – (specify)
OFFENSIVE WASTE **Please note this waste is not infectious and does not require specialist clinical waste disposal and can be placed in the residual waste.**					
6	Any other relevant information:				

Return completed form by email to wmadmin@tendringdc.gov.uk or to Tendring District Council, 88-90 Pier Avenue, Clacton-on-Sea, Essex CO15 1TN

Originators Details	
Healthcare Professional (Print Name)	
Contact Telephone No	
Address	

Signed (Healthcare professional)..... Date.....

Sections to be completed by Tendring District Council

Local Authority Reference Number	TDC/
Date	

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