

**REGULATED MEDICAL WASTE TRANSPORTER ANNUAL REPORT CERTIFICATION FORM**  
**NEW JERSEY DEPARTMENT OF ENVIRONMENTAL PROTECTION**

Division of Sustainable Waste Management - Bureau of Recycling and Hazardous Waste Management  
(609) 984-3438

**Reporting period 7/01/20 to 6/30/20**

**Transporter Name**

**NJDEP Medical Waste Identification Number**

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**Certification**

I certify that I have personally examined and am familiar with the information submitted in this and all attached documents, and based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate and complete.

Name and official title of owner or owner's authorized representative

**Signature**

**Title**

**Date**

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**Upon completion, the certification PDF is to be filled out and attached to an email along with the Excel workbook. Failure to attach both the certification PDF and the Excel workbook together will result in noncompliance. Both documents should be sent as an email to [rmwtransporterannualreports@dep.nj.gov](mailto:rmwtransporterannualreports@dep.nj.gov)**

**NOTE: This certification may be signed electronically using a digital ID in Adobe Reader or printed, signed by hand and scanned back in as a PDF document.**  
**DO NOT print and scan the Excel workbook.**