



Request for Domestic Clinical Waste Collection

Please will you arrange to make collections of clinical waste from my patient, as follows:

Patient details

Name:

Address:

Contact telephone:

Rationale for seeking a clinical waste collection

Type of waste:

Quantity of waste generated per week:

Referred by:

GP / Practice Nurse:

Surgery details:

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.....

I confirm that the patient's need for a clinical waste collection is in accordance with the agreed arrangements.

Signed

Date:

This form, when completed, should be sent to:

Single Shared Waste Service
South Cambridgeshire DC and Cambridge City Council
Dickerson Industrial Estate | Ely Road | Waterbeach | Cambridge | CB25 9PG