EXEMPTION CLAIM FORM FOR CO-FIRED COMBUSTORS

FACILITY INFORMATION	
	y Name:
Facility A	Address:
G	
Contact Person	Phone:
	Fax:
Type of	Facility:
	WASTE INFORMATION
Please provide t (i.e., every three	ne distribution of the types of waste combusted in the incinerator each quarter months):
% Hosp	tal waste and medical/infectious waste (excluding wastes marked with a * below
% *Path	ological waste, low-level radioactive waste, and chemotherapeutic waste
% Other	waste/fuel ¹
Does the inci	nerator accept waste from off-site? Yes No
Lb/Hr	How many pounds of waste/fuel ¹ are typically charged per hour?
Hr/Day	How many hours per day is waste/fuel ¹ charged into the incinerator?
Lb/Qtr	How many pounds of waste/fuel ¹ are typically charged per quarter?
Please attac	an explanation of the methodology that will be used on an ongoing basis estimate the percentages of waste types discussed above.
	CERTIFICATION
examined the for all attachments obtaining the in that there are simprisonment.	d to make this submission on behalf of the owners and operators of and I hereby certify under penalty of law that I have personally regoing and am familiar with the information contained in this document and and that based on my inquiry of those individuals immediately responsible for formation, I believe the information is true, accurate and complete. I am aware gnificant penalties for submitting false information including possible fines and In addition, it is my understanding that I am not subject to a Major Source at under Chapter 335-3-16 based solely on the requirements of ADEM Admin04.
(Signature of Re	sponsible Official)

¹ Excluding fuels such as propane or natural gas used to maintain combustion chamber temperatures