

HOSPITAL NAME: _____

ADDRESS: _____

CONTACT PERSON: _____ POSITION: _____

TEL. NO.: _____ EMAIL: _____ MOBILE NO.: _____

PRESIDENT: _____ CONTACT NO.: _____

HOSPITAL ADMINISTRATOR: _____ CONTACT NO.: _____

MEDICAL DIRECTOR: _____ CONTACT NO.: _____

NAME OF PCO: _____ CONTACT NO.: _____

AGE OF HOSPITAL: _____ REGISTERED BED CAPACITY: _____ ACTUAL BED COUNT: _____

CATEGORY: _____ GOVERNMENT _____ PRIVATE _____ NGO

LEVEL: _____ PRIMARY _____ SECONDARY _____ TERTIARY

WATER CONSUMPTION (VOLUME): _____

DISPOSAL METHOD (WASTEWATER):

_____ SEPTIC TANK _____ PUBLIC DRAINAGE _____ SIPHONING _____ SEWER

OTHERS: _____

TREATMENT METHOD (WASTEWATER):

_____ GREASE TRAP _____ CHLORINATION _____ MEMBRANE BATCH REACTOR

_____ SEPTIC TANK _____ SEQUENCING BATCH REACTOR

_____ STP _____ OZONATION _____ ROTATING BIOLOGICAL CONTACTOR

OTHERS: _____

TOXIC/HAZARDOUS WASTE: _____ CHEMICALS _____ BLOOD _____ MEDICINE _____ PATHOGEN _____ OIL

OTHERS: _____

ANY NOTICE FROM LLDA/DENR: _____ YES _____ NO

AWARE OF CLEAN WATER ACT (PENALTIES & REGULATION) _____ YES _____ NO

ACTION PLAN/REQUIREMENTS:

_____ SUBMIT _____ REQUEST FOR PROPOSAL _____ SECURE BUILDING PLAN

_____ WW SAMPLE _____ PICTURES _____ OCULAR INSPECTION _____ SEPTIC TANK/DRAINAGE LOCATION

REMARKS: _____

PREPARED BY: _____ REFERRED BY: _____ DATE: _____