Infectious Waste Transporter
Certificate of Insurance
Bureau of Land and Waste Management

Name and address of insured/transporter:

Name and address of insurer/company affording coverage:

Type of Coverage	Policy#	Amount of Deductible	Policy Expiration Date	Limits of Liability (exclusive of legal defense cost)
Underlying or Primary				
Excess liability (requires endorsement 1)				

If any of the above listed policies include any exemptions, exclusions, and/or conditions which would limit the extent of coverage as intended under the South Carolina Infectious Waste Management Regulations, R.61-105, please attach copies of these exemptions and/or conditions to the back of this form.

It shall be the responsibility of the registered transporter to resubmit a Certificate of Insurance Form upon expiration of the present policy.

This certificate and the endorsement described herein may not be cancelled without cancellation of the policy to which they refer. Such cancellation may be effected by the company or the insured giving thirty (30) days notice in writing to the SC Department of Health and Environmental Control with which such certificate has been filed, such thirty (30) days notice shall also be given, at the address below, if there is any material change made in the policy or endorsement to which this certificate refers.

The undersigned do hereby certify that the aforementioned applicant meets all requirements for financial responsibility as defined in Regulation 0. (1) (f) of the Infectious Waste Management Regulations, R. 61-105 promulgated pursuant to authority contained in the South Carolina Infectious Waste Management Act whereby a transporter of infectious waste shall have and shall maintain financial responsibility for sudden and accidental occurrences in a minimum amount of one million ($1,000,000) dollars exclusive of legal defense cost.

Underlying or Primary Carrier
Signature of Authorized Representative of Insurer
(must be original signature)

____

Type name ______________________________

Title ___________________________________

Address _________________________________

____

Date ______________ Policy # ____________

Phone __________________________________

Excess Liability Carrier
Signature of Authorized Representative of Insurer
(must be original signature)

____

Type name ______________________________

Title ___________________________________

Address _________________________________

____

Date ______________ Policy # ____________

Phone __________________________________

Please return this completed, original form to:
South Carolina Department of Health and Environmental Control
Bureau of Land and Waste Management, Infectious Waste Program
2600 Bull Street, Columbia, South Carolina 29201