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| **FORM 1**  **MISSISSIPPI DEPARTMENT OF ENVIRONMENTAL QUALITY**  **P.O. BOX 2261**  **JACKSON, MISSISSIPPI 39225**  **APPLICATION FOR**  **MEDICAL WASTE TRANSPORT CONTRACTOR**  **GENERAL INFORMATION/PROOF OF INSURANCE** | | | | | | | | | | |
| Name of Applicant: | |  | | | | | | | | |
|  | | | | | | | | | | |
| P. O. Box or Street Address: | | | | |  | | | | | |
|  | | | | | | | | | | |
| City: |  | | | | | | State: |  | Zip: |  |
|  | | | | | | | | | | |
| Principal Officer Name: | | |  | | | | | | | |
|  | | | | | | | | | | |
| Telephone: | | | |  | | | | | | |
|  | | | | | | | | | | |
| E-mail Address: | | | | | |  | | | | |
|  | | | | | | | | | | |
| Usual Company Contact Name: | | | | | |  | | | | |
|  | | | | | | | | | | |
| Telephone: | | | |  | | | | | | |
|  | | | | | | | | | | |
| E-mail Address: | | | | | |  | | | | |
| Attach with this form proof of Worker’s Compensation and Employer’s Liability Insurance as required by Section 3 of this Request for Applications. Proof may be provided by attaching copies of pages of the insurance policy that include the name of the insurance company providing coverage, the policy number, and the amount of coverage. Any other information considered confidential by the Applicant may be redacted. | | | | | | | | | | |