

State Agency Model Integrated Waste Management Plan

Part I-A: State Agency Information

State Agency Name: _____

Address: _____

City: _____ ZIP Code: _____

State Agency Director's Name: _____

Recycling Coordinator:

Name: _____

Address: _____

City: _____ ZIP Code: _____

Telephone Number: (____) _____ FAX Number: (____) _____

E-mail Address: _____

Total Number of Employees: _____

Check this box if the State agency is submitting a modified integrated waste management plan, because the agency has less than 200 full-time employees and generates less than 100 tons of waste statewide, per year.

The signature below serves to certify that this integrated waste management plan is consistent with and meets the requirements of PRC 42920 (b).

Signature of Chairman, Commissioner,
or Director

Date

Printed Name

Title