



Hospital Sterilizers using Ethylene Oxide

ANNUAL NOTIFICATION OF COMPLIANCE

Applicable Rule: 40 CFR Part 63, Subpart WWWW – National Emission Standards for Hazardous Air Pollutants (NESHAP) for Hospital Sterilizers using Ethylene Oxide

Air Quality Control Division
 5600 South 10th Street
 Omaha NE 68107-3501
 Phone: (402) 444-6015
 Fax: (402) 444-3904

This form must be completed, signed and submitted to Omaha Air Quality Control by March 31st of each year.

(1) City of Omaha- Air Quality Control, 5600 S. 10th Street, Omaha, NE 68107

Who is subject to this Rule?

1. Hospitals using ethylene oxide sterilization.

SECTION I – GENERAL INFORMATION

Print or type the following information for each facility for which you are submitting notification:

Facility Name	
Facility Address	City, State, Zip
Responsible Official's Name/ Title	Responsible Official's Phone Number
Responsible Official's Mailing Address/Billing Address (if different than above)	City, State, Zip

For official use only: City ID#

State ID#

SECTION II – APPLICABILITY AND COMPLIANCE STATUS

1. Compliance Requirements

- i. List the number of ethylene oxide sterilizers: _____
- ii. List the number of separate aeration units: _____
- iii. For each sterilizer, please provide (attach a separate sheet if necessary):

Sterilizer ID	Sterilizer Volume	Number of Sterilizer Cycles Last Year	Is the Sterilizer vented to an add-on Air Pollution Control Device (APCD)?	Type of add-on Air Pollution Control Device (if applicable)
	_____ft ³	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
	_____ft ³	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
	_____ft ³	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

2. Compliance Demonstration

- I certify that this source sterilizes full loads of medical items having a common aeration time, except under medically necessary circumstances.
- The sterilization unit(s) operates with add-on APCD(s) (for reducing EO emissions to the atmosphere) pursuant to a State or local regulation. ID State or local regulation: _____. I certify that the sterilization unit operates in accordance with the State and local regulation and follows the add-on APCD manufacturer’s recommended practices.
- The sterilization unit(s) operate(s) with add-on Air Pollution Control Device(s) (APCD) (for reducing ethylene oxide emissions to the atmosphere) but are not subject to any State or local regulation for limiting ethylene oxide emissions. I certify that the sterilization unit(s) operate(s) by venting ethylene oxide emissions from each unit to an add-on APCD and certify that the add-on APCD (for reducing ethylene oxide emissions to the atmosphere) operates during all sterilization processes and follows the add-on APCD manufacturer’s recommended practices.

3. Record-keeping Requirements

The following records must be maintained for at least two years onsite and five years total:

1. All notifications submitted for this regulations
2. All sterilization cycle records for each sterilizer not equipped with an APCD, including:
 - a. Date and time of each sterilization cycle
 - b. Whether the cycle was run full or not
 - c. If not run full, a note from hospital staff that it was medically necessary

Are all five years of compliance records located at the facility’s physical address listed above?

- Yes
- No

If you answered No above, provide the address where the records are kept:

Address	City, State, Zip
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SECTION III – CERTIFICATION

The Responsible Official must certify below. The Responsible Official can be:

- The president, vice president, secretary, or treasurer of the company that owns the facility;
- An owner of the facility;
- The plant engineer or supervisor of the facility;
- A government official, if the facility is owned by the Federal, State, City, or County government; or
- A ranking military officer, if the facility is located at a military base.

(Print or type the following information.)

Name: _____ Title: _____

Telephone Number: _____ Email: _____

I CERTIFY THE INFORMATION CONTAINED IN THIS REPORT TO BE ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

(Signature of Responsible Official)

(Date)