INFORMATION VERIFICATION REQUEST

Facility Name:_____

Address: _____

_____

Phone Number: _____

Facility type (please tick):

- ☐ **Pharmacy**
- ☐ **Hospital**
- ☐ **Public Facility**
- ☐ **Community Health**
- ☐ **Needle & Syringe Program**

We provide the following services (please tick):

- ☐ **Single Sharp Disposal**
- ☐ **Sharps Container Disposal**
- ☐ **Sale of Sharps' Containers/Bins**

What are your opening hours (please tick):

Day	***Opening Time***	***Closing Time***	***Open 24 Hours***
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

I certify that the above information is correct and authorise its inclusion on the *safesharps.org* website.

_____ _____ _____

Name Signature Date

_____

Position

Please complete and return to: Email: mail@reroc.com.au OR Fax: 02 6931 9040