Clear Form

STATE OF HAWAII - DEPARTMENT OF HEALTH
MOTOR VEHICLE TIRE RECOVERY SUMMARY
July 1, 2015-June 30, 2016

SECTION A -- BUSINESS LOCATION INFORMATION

Business Name: agency, business, trade, and d/b/a name	Business Phone:
Contact Person: if different from representative authorized to sign below	Contact Phone/Email:
Business Location, City/State/ZIP: Complete physical address of business or real property. Listing a post office box or rural route number as your business location is not permitted.	

1. Please check the activity/activities engaged by your business:

❑ Sale of new tires ❑ Sale of used/recapped tires ❑ Auto salvage/scrap yard
❑ Tire distribution center ❑ Used tire processor ❑ Refuse hauler
❑ Motor vehicle repair ❑ Tire transporter ❑ Other _____

NOTE: If you operate in more than one location, complete an annual summary for each location.

SECTION B -- USED TIRE COLLECTION / DISPOSAL INFORMATION

2. During the reporting period, who did you accept used tires from? **# TIRES**

a. General public _____

b. Tire retail, repair shops, or other establishment (List name and location. Use one line for each location. Attach a separate sheet if necessary)

_____ _____

_____ _____

_____ _____

TOTAL _____

3. Where were your used tires taken to, once collected? Include transporter information also, if applicable. (Attach separate sheet if necessary)

a. Business Name: _____ **# TIRES** _____
Address/Contact: _____

b. Business Name: _____ **# TIRES** _____
Address/Contact: _____

c. Still on-site: . . . . . **# TIRES** _____

d. Other (explain): _____ **# TIRES** _____

If more sheets are attached for this Section, check here ❑.

(over)

SECTION C -- DECLARATION AND SIGNATURE

Important: Any person (including but not limited to employees, corporate directors, corporate officers, etc.) who is required to maintain records, and provide this summary and fails to do so shall be liable for penalties pursuant to Chapter 342I, Part II, Hawaii Revised Statutes, as amended.

I declare that I have read and examined the foregoing summary and that the facts stated in it are true.

Sign Here _____ Title _____

Print Name _____ Date _____

NOTE: If the facility is a partnership or group other than a corporation or a public entity, the summary shall be made by one individual who is a member of the group. If the facility is a corporation or a public entity, the summary shall be made by an officer of the corporation, general manager of the business, or an authorized representative of the public entity.

Mail to: State of Hawaii
Department of Health
Office of Solid Waste Management
919 Ala Moana Blvd. Rm. 212
Honolulu, HI 96814
http://health.hawaii.gov/shwb/solid-waste/

Phone: (808) 586-4226
Fax: (808) 586-7509

THIS ANNUAL SUMMARY MUST BE SENT OR POSTMARKED ON OR BEFORE JULY 31, 2016