附件2

医疗废物收集情况日报表

报送日期： 年 月 日 集中收集处置单位：

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| **医疗机构**  **名称** | **所属市** | **所属区** | **感染性废物** | | **损伤性废物** | | **病理性废物** | | **药物性废物** | | **化学性废物** | | **小计** | |
| **数量（箱）** | **重量（kg）** | **数量（箱）** | **重量（kg）** | **数量（箱）** | **重量（kg）** | **数量（箱）** | **重量（kg）** | **数量（箱）** | **重量（kg）** | **数量（箱）** | **重量（kg）** |
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