SOLID WASTE SERVICES DISABILITY EXEMPTION REQUEST FORM

Name: _____

Address: _____

Telephone Number: _____ Cell Number: _____

Read the following statement carefully, and check beside it if you agree.

☐ I request Disability Exemption because I am unable to bring my garbage container to the curb, and there is no living or employed (part or full time) in my household who is able to move such container to the curb.

☐ I give permission to solid waste services personnel to enter the above referenced property for the purpose of collecting solid waste and hereby waive any claim against the City of Sweetwater or its Provider for any damages in connection with solid waste services personnel entering this property for the purpose of solid waste collection.

☐ I understand my garbage container will need to be located in an accessible area as solid waste services personnel cannot enter structures or gated areas to retrieve or return such container.

☐ I acknowledge I will notify the Solid Waste Services if my need for this service ceases.

☐ I authorize my physician to release any information as may be needed to verify my disability.

My reason for needing assistance is (check one):

☐ I have a permanent physical disability.
☐ I have a temporary physical disability until (Date) _
☐ I understand that after this date, I will be removed from the Need Assistance list.

☐ I understand that Disability Exemption is for garbage collection only, not yard waste. I also understand that this service may be revoked at any time by the Solid Waste Services if I no longer qualify for assistance. This determination may be made based on observations by Solid Waste Services employees.

Signature: _____ Date: _____

PHYSICIAN'S STATEMENT

For medical reason(s), the above individual is unable to and should not move the garbage cart to the curb each week. I have checked the correct status --- either permanent or temporary. If temporary, I have indicated how long the customer will need assistance with collection service.

Physician Name: _____

Physician Address: _____

Physician Signature: _____ Date: _____

FOR SOLID WASTE SERVICES USE ONLY

Date Received: _____ Date Customer Contacted: _____

Date of Site Visit (if needed): _____ Not Approved for reason: _____

Name: _____ Signature: _____