

**WALK-UP SERVICE REQUEST FORM
GARBAGE & RECYCLE COLLECTION**



This application is a request for WALK-UP SERVICE with Johns Disposal for Automated Garbage & Recycling Collection. This service may be requested by a licensed physician on behalf of a patient / resident for whom the moving of provided 48, 65 or 95-gallon wheeled garbage and recycling carts would present an unnecessary hardship or is impractical by reason of physical condition or medical problem.

Office Use Only Date Request Received:		PLEASE PRINT OR TYPE				
PART A: TO BE COMPLETED BY APPLICANT						
Last Name:		First:	MI:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:	Are you able to wheel carts to the curb for collection? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you the legal property owner? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is the property owner's name?			Property Owner Contact Phone:	
Street Address:			Home Phone Number:		Mobile Phone Number:	
Mailing Address:			City, Town, Village:	State:	ZIP Code:	
<p>I, the undersigned applicant, certify that I am <input type="checkbox"/> permanently OR <input type="checkbox"/> temporarily disabled and unable to wheel my garbage and recycling carts to the curb for collection. I also certify that there is no one in my household, in my employ, or providing in home assistance to me from a third party that is able to get my carts to the curb. I authorize my physician to release any information necessary to verify my disability.</p>						
Applicant's Signature					Date	

PART B: TO BE COMPLETED BY PHYSICIAN						
Physician Name:		Physician Type:		License Number:		
Physician Address:		City, Town, Village:		State:	ZIP Code:	
Physician Telephone Number:		Physician Fax Number:		Physician Email:		
<p>Note to Physician: <i>By completing and signing this form, you are indicating that it is harmful or impractical for the patient / applicant named above to use these specifically required 48, 65, or 95-gallon wheeled carts for the collection of garbage and recycling due to his or her physical condition or medical problem.</i></p>						
Is the applicant your patient?		<input type="checkbox"/> Yes	<input type="checkbox"/> No			
<p>Physician statement & request for exemption. <i>Describe how use of the wheeled garbage and recycling carts would be harmful or impractical for your patient to use. Include the specific reason you believe Walk-Up Service is necessary.</i></p>						
This exemption should be:		<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary until	(month)		(year)

I certify by my signature that I am a physician licensed to practice medicine in Wisconsin, and that in my judgment the patient named above should be granted Walk-Up Service for Garbage & Recycling as described in this request.

Physician Signature		Date	
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