

SPECIAL WALK-UP SERVICE REQUEST FORM

This application is a request for SPECIAL WALK-UP SERVICE in the City/Town/Village of _____ with Waste Management (WM) for Garbage & Recycling Collection. This special service may be requested by a licensed physician on behalf of a patient for whom the moving of the wheeled garbage and recycling carts would present an unnecessary hardship or is impractical by reason of physical condition or medical problem. **Please allow a minimum of five business days for processing this exemption request.**

Office Use Only Date Request Form Received: _____

PLEASE PRINT OR TYPE

Part A: To be completed by applicant

Last Name:	First:	Middle:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:	Are you or anybody within your household able to wheel your 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:	Town:	State: WI	ZIP Code:		

I, the undersigned applicant, certify that I am permanently 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.

Applicant's Signature _____

Date _____

Part B: To be completed by physician

Physician's Name:	Physician Type:	License Number:	
Physician's Address:	Town:	State:	Zip Code:
Telephone Number: ()	Fax Number: ()	Email:	

Note to Physician: Please review the description of the wheeled household garbage and recycling collection carts on page 1 of this application form prior to signing. 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 wheeled carts for the collection of garbage and recycling due to his or her physical condition or medical problem.

Is the applicant your patient? Yes No

Physician statement and request for patient exemption from use of wheeled garbage and recycling collection carts. Describe how use of the wheeled household garbage and collection carts would be harmful or impractical for your patient to use. Include the specific reason you believe Walk-Up Service to be justified. Please print clearly or type.

This exemption should be:

- Permanent
 Temporary until _____

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 Special Walk Up Service for Garbage & Recycling Collection as described in this request.

Physician's Signature

Date