WALK-UP SERVICE REQUEST FORM

GARBAGE & RECYCLE COLLECTION

JOHNS DISPOSAL SERVICE INC.
Whitewater & Franksville, WI

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: ☐ Male ☐ Female	Age:	Are you able to wheel carts to the curb for collection? ☐ Yes ☐ No

Are you the legal property owner? ☐ Yes ☐ 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:

I, the undersigned applicant, certify that I am [ ] permanently OR [ ] 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 Name:	Physician Type:	License Number:

Physician Address:	City, Town, Village:	State:	ZIP Code:

Physician Telephone Number: ( )	Physician Fax Number: ( )	Physician Email:

Note to Physician: *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*.

Is the applicant your patient?	☐ Yes	☐ No

Physician statement & request for exemption. *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.*

This exemption should be:	☐ Permanent	☐ 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