City of West Columbia Public Works

Sanitation Division
P. O. Box 4044
West Columbia, SC 29169
phone 803-796-8006 fax 803-936-6001

MEDICAL/PHYSICAL DISABILITY VERIFICATION FORM

Residential Garbage & Recycling Collection Program

To participate in the City of West Columbia's Residential Garbage & Recycling Collection Program, citizens are required to put household garbage generated at the residence into a city provided "roll cart" (the "roll cart" has a capacity of approximately 90 gallons) and recycling into an 18-gallon recycle bin. To be emptied, the cart and bin must be placed at the curbside of the nearest public roadway on the specified collection day. Citizens with a verifiable medical or physical disability that prevents them from meeting these requirements may submit a completed Medical/Physical Disability Verification Form to the Public Works Department to request a waiver of the curbside collection requirement. With an approved waiver, city personnel will provide special service by collecting the roll cart and recycle bin from a designated location other than at the curbside. By accepting this waiver, you authorize City personnel and equipment to enter your property for this purpose.

Applicant Information

_____
Last Name First Name M. I.

_____
Street Address

_____
City State Zip

_____
Daytime Telephone # Evening Telephone #

By signing below, I declare that:

- I am eligible for special collection of household garbage and recyclable items due to a medical or physical disability that prevents me from placing the roll cart and recycle container at the curb for collection, and
- that no other resident at the above listed address is reasonably able or expected to satisfy the requirement of placing these containers at the curb.

_____
Signature Date

_____
Signature of Notary Date

My commission expires: _____

Physician Information

To be completed by Physician

This is certify that:

- I am familiar with the physical requirements necessary for the above-named individual to place her/his waste containers at the curb; and,
- I have completed a medical examination of the above-named individual, and,
- based on my medical training, I have determined that she/he is unable to meet those requirements because of a medical or physical disability.

_____
Signature Date

_____
Print Name

_____
Address

_____
City State Zip

_____
Telephone # FAX #

PLEASE RETURN COMPLETED FORM TO THE PUBLIC WORKS DEPARTMENT AT THE ADDRESS OR FAX NUMBER ABOVE

Pubic Works Department Office Use Only

Date Received at Public Works	**Date of Follow up**	**Follow up by**	**Date Approved**
Collection Day	**Roll Cart #**	**Area/Sub-Division**	**Date Disapproved**
Signed		**Date**	**Date Applicant Notified**