WEST COLUMBIA
• HEAD WEST •

Rev 06/22

MEDICAL/PHYSICAL DISABILITY VERIFICATION FORM

Residential Garbage & Recycling Collection

Customer Service • 200 N. 12th Street, West Columbia, SC 29169
(803)791-1880 • sanitation@westcolumbiasc.gov

Please return form to the Customer Service Department at the address or email listed above.

Requirements

To receive the City of West Columbia's Residential Garbage and Recycling Collection services, residents are required to put household garbage and recycling in the city-provided roll carts and place them curbside to the nearest public roadway on the specified collection day. Residents with a verifiable medical or physical disability that prevents them from meeting these requirements can complete this Medical/Physical Disability Verification Form and submit it to Customer Service to request a waiver of the curbside roll cart placement requirement. With an approved waiver, City personnel will accommodate the customer by collecting the garbage and recycling roll carts from a designated location other than curbside.

By accepting this waiver, you authorize City personnel and equipment to enter your property for this purpose and to place an obscure yellow dot on the roadside or curb that will make the address identifiable to sanitation employees.

Application Information

Last Name _____ First Name _____ MI _____

Physical Address for Pick-Up _____

Email Address _____ Home/Cell Phone _____

By signing below, I declare:

- I am eligible for an accommodation concerning the collection of household garbage and recyclable items due to a medical or physical disability that prevents me from placing the garbage and recycling roll carts at the curb for collection, and
- No other resident at the above listed address is reasonably able to expected to satisfy the requirement of placing these containers at the curb.

Signature _____ Print Name _____ Date _____

Physician Information

Must be completed by Physician

This is to certify:

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

Signature _____ Print Name _____ Date _____

Name of Medical Practice _____

Address _____

City _____ State _____ Zip Code _____

Office Phone Number _____ Office Fax Number _____

Office Use Only

Date Received _____ Staff Member Assigned _____ Date of Follow Up _____

Collection Day _____ Roll Cart Number _____ Area/Subdivision _____

Date Approved _____ Date Denied _____ Date Applicant Notified _____

Approved By _____ Signature _____ Date _____