

City of Madison, Streets Division
1501 W. Badger Rd., Madison, WI 53713 FAX 267-1120

Application For Residential Disabled Roll Out Service

Applicant Information

Name: _____

Residential Address: _____

Zip Code: _____ Phone Number: _____

Applicant's Verification of Disability and Household Occupancy

I, the undersigned applicant, certify that I am ____ temporarily ____ permanently disabled and unable to push my recycling./refuse cart to the curb. 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 understand that it is my responsibility to re-submit this form annually from this date for continuance of residential disabled roll out service.

I authorize my physician or optometrist to release any information necessary to verify my disability.

Signature of Applicant: _____

Date: _____

Disability Statement

To be completed by a Licensed Physician (or Optometrist if Applicant is legally blind)

I, a licensed physician or optometrist, hereby certify that

_____ is currently disabled as described below and unable to get his/her recycling/refuse carts to curb.

Nature of disability:

I further certify that this disability is _____ temporary in nature (Length of disability is from _____ to _____)

_____ permanent nature continuing for the applicant's lifetime.

Name of Physician or Optometrist:

Address: _____

Phone: _____

Signature: _____

Date: _____