CITY OF SEQUIM
152 West Cedar Street, Sequim, WA 98382
City Hall (360) 683-4139 FAX (360) 681-3448
Public Works (360) 683-4908 FAX (360) 681-0552

ROLL OUT GARBAGE SERVICE FOR ELDERLY & DISABLED CUSTOMERS

A program has been established to allow for roll out service of garbage bins by the hauler, limited to disabled or elderly customers that are unable to roll out their bins of their own accord, and that lack other methods of assistance to perform this activity such as neighbors, caregivers, etc. An authorization from a health care provider is required to utilize this service.

This service is offered at a fee paid to the hauler on the regular service bill issued by the hauler. This application, once completed, should be submitted to the hauler at 970 Carlsborg Rd. Visit www.wasteconnections.com/sequim/ for more contact information.

If this service is no longer required, the customer must contact the hauler to discontinue this service and stop this fee. Customers using this service under unwarranted circumstances may be discontinued at the hauler's discretion.

Name: _____

Phone Number:_____

Mailing Address:

_____

_____

Account number(s): _____

Physical Address: _____

_____

Rent: _____ Own: _____

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:_____

Healthcare provider—Doctor, physician, or licensed registered nurse practitioner fills out this section. **You must provide a separate signed authorization** stating: (1) applicant's name (2) they have a condition which qualifies them for disabled services. This authorization must be on prescription paper or your office letterhead. Return this form and your singed authorization to the applicant.

PRINT Name_____

Professional classification_____

Professional license number_____

Office Address (Street, City, State, ZIP code)_____

Phone number:_____

Service duration: Permanent____ Temporary____ for: _____ months

Answer the following:

_____My patient meets at least one of the following qualifying conditions:

- Cannot walk 200 feet without stopping to rest or must use assistive device
- Walking severely limited due to arthritic, neurological or orthopedic condition
- Uses portable oxygen or walking restricted by lung disease
- Class III or IV impairment by cardiovascular disease
- Acute sensitivity to auto emissions that limits ability to walk
- Legally blind with limited mobility
- Restricted by porphyria (applicant benefits from a decrease in exposure to light)