Lexington County Solid Waste Management
David L. Eger, Director
498 Landfill Lane
Lexington, SC 29073-7831
Phone 803-755-3325 Fax 803-755-3833

MEDICAL/PHYSICAL DISABILITY VERIFICATION FORM

Franchise Curbside Collection Program

As a participant in the Lexington County Solid Waste Management Franchise Curbside Collection Program, citizens are required to put household garbage and recyclables generated at the residence into company provided "roll carts" (each "roll cart" has a capacity of approximately 95 gallons). In addition, the "roll carts" must be placed at the curbside of the nearest public or private road/street/highway 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 Director of Solid Waste Management to request a waiver of the curbside requirement. With an approved waiver, the Franchise Service Provider will collect the "roll carts" containing household garbage and recycling materials from a designated location adjacent to the house but not more than 150 feet from the nearest public or private road/street/highway on the specified collection day, at the curbside rate. (Recycling pick up is not available in "rural areas" within Franchise Districts 5 and 6.)

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 back yard collection of household garbage due to a medical or physical disability that prevents me from placing my household garbage 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 this household garbage at the curb.

_____
Signature Date

_____
Signature of Notary Date

My commission expires: _____

Physician Information

To be completed by Physician

This is to certify that:

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

_____
Signature Date

_____
Print Name Professional License Number

_____
Address

_____
City State Zip

_____
Telephone # FAX #

SWM OFFICE USE ONLY

Date Received By SWM	**Follow Up By**	**Date Approved**
Franchise Service Provider	**Area Number** **Date Notified**	**Date Disapproved**
Signed	**Dated**	**Date Applicant Notified**