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 a 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 at the curbside rate.

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**