

Lexington County Solid Waste Management

Joe G. Mergo, III, 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 generated at the residence into a company provided "roll cart" (the "roll cart" has a capacity of approximately 90 gallons). In addition, the "roll cart" 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 cart" containing household garbage 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 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 at SWM Follow up by

Date Approved

Franchise Service Provider Date Notified

Date Disapproved

Signed Date