City of New Holstein
2110 Washington St., New Holstein, WI 53061
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APPLICATION FOR WASTE/RECYCLING EXEMPTION SERVICE PROGRAM

APPLICANT INFORMATION (please print)

Name:	First	Last
Residential Address:		
Phone Number:		

Applicant's Verification of Disability and Household Occupancy

I, the undersigned applicant, certify that I am (check one) ☐ **temporarily** ☐ **permanently** disabled and unable to push my waste/recycling 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 move my carts to the curb or location of waste/recycling pick-up. 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 Signed: _____

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 (name of applicant) _____ is currently disabled as described below and unable to get his/her waste/recycling carts to the curb.

Nature of Disability:

_____

_____

_____

_____

I further certify that this disability is (check one) ☐ temporary in nature (Length of disability is from _____ to _____) I further certify that this disability is ☐ permanent in nature continuing for the applicant's lifetime.

Name of Physician or Optometrist: _____

Address:	City, State, Zip:
Phone:	
Signature:	
Date:	

Mail, email or fax completed form to the address indicated at the top of this document.