

MEDICAL DOCUMENTATION FOR EXEMPTION SERVICE

This is a special service provided to residents who are disabled or physically unable to place their refuse at the designated point of collection, and do not have any available relative, friend or neighbor who can perform this task for them. While the City of Akron is able to provide this service, we must limit its availability to those whose mobility is medically and physically impaired.

We request that the resident fill out the questionnaire, and that medical documentation be provided to verify the need of each resident who receives exemption service.

Please remember to have your physician sign the medical documentation.

City of Akron
Department of Public Works
Sanitation Division
EXEMPTION SERVICE QUESTIONNAIRE
(To be completed by the resident)

NAME: _____ ADDRESS: _____

ZIP: _____ PHONE NUMBER: _____

AGE: _____ NUMBER LIVING IN HOUSEHOLD: _____

AGE(S) OF ADDITIONAL PERSON(S) LIVING IN HOUSEHOLD:

TYPE OF REFUSE CONTAINER REQUESTED FROM THE CITY OF AKRON:

96-Gallon _____ 64-Gallon _____

DO YOU WISH TO RECYCLE? YES _____ NO _____

WHO ROUTINELY PLACES YOUR REFUSE OUT FOR COLLECTION? _____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE FOR A CHRONIC ILLNESS WHICH IMPAIRS MOBILITY? YES _____ NO _____

WHAT TYPE: WHEELCHAIR _____ WALKER _____ CANE _____

DO YOU HAVE A FRIEND, NEIGHBOR, OR RELATIVE WHO IS WILLING TO PLACE YOUR REFUSE AT THE DESIGNATED POINT OF COLLECTION?

YES _____ NO _____

REASON FOR REQUESTING EXEMPTION SERVICE: _____

TODAY'S DATE: _____

PLEASE ATTACH THE MEDICAL CERTIFICATION FORM, and send both forms to:
Bureau of Public Works Sanitation Division
1436 Triplett Boulevard
Akron, OH 44306

MEDICAL DOCUMENTATION FOR EXEMPTION SERVICE

The Sanitation Division has received a request from a resident who is applying for exemption service.

This is a special service provided to residents who are disabled or physically unable to place their refuse at the designated point of collection.

If a resident is physically unable to transport a city-provided refuse container to the curb and they do not have any available relative, friend or neighbor who can perform this task for them, the service will be provided to those whose mobility is medically and physically impaired.

We request that medical documentation be provided to verify the need of each resident who receives exemption service. Please fill out the lower portion of this letter on behalf of your patient who is currently receiving this service. Your cooperation in this matter is greatly appreciated.

I hereby give consent to my physician to release information to the Refuse Collection Division about my condition.

Resident's Name: _____

Resident's Signature: _____

Address: _____

Zip Code: _____

Doctor's Certification for Exemption Service

I hereby certify that _____ is under my care

for the treatment of _____

which impairs mobility and physically restricts the patient from placing their refuse at the designated point of collection.

Physician's Name

Physician's Signature

Date