



Automated Waste Disposal & Recycling Collection Program: Assistance for the Physically Unable

The purpose of this program is to assist persons who are physically unable to utilize the automated collection system on their own and have no assistance available to them. The City of Oconomowoc has set up a program to help these residents get their recycling and refuse collected.

Qualified resident's will have their carts wheeled from outside their home to the curb and then back to their home by service technicians/drivers.

To qualify for the Residential Physically Unable Roll-Out Service resident must:

1. Be unable to wheel their cart(s) to the curb for collection.
2. Have no one else who can assist them such as a spouse or other live-in family member or personal assistant.
3. Be certified by a practicing and licensed physician as needing assistance. The signing physician should be a non-family member.
4. **Fill out and return the required Application for Residential Roll-Out Service (*bottom of page*) with the Physically Unable Statement, (*page 2*) signed by a physician.**

Please return by mail to:

City of Oconomowoc
Attn: Kailey-Jo Gruling
P.O. Box 27
Oconomowoc, WI 53066

You will be notified by phone after your application has been received.

Applicant Information

Name: _____

Residential Address: _____

City: _____

Phone Number: _____ Email: _____

Applicant's Verification of Disability and Household Occupancy

I, the undersigned applicant, certify that I am ____ temporarily ____ permanently physically unable to push my recycling/refuse carts 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 get my carts to the curb. I understand that I may be required to re-submit this form annually from this date for continuance of this residentially physically unable roll out service. I authorize my physician or optometrist to release any information necessary to verify my disability.

Signature of Applicant: _____ Date: _____

**WALK-UP SERVICE REQUEST FORM
GARBAGE & RECYCLE COLLECTION**



This application is a request for WALK-UP SERVICE with Johns Disposal for Automated Garbage & Recycling Collection. This service may be requested by a licensed physician on behalf of a patient / resident for whom the moving of provided 48, 65 or 95-gallon wheeled garbage and recycling carts would present an unnecessary hardship or is impractical by reason of physical condition or medical problem.

Office Use Only Date Request Received:		PLEASE PRINT OR TYPE				
PART A: TO BE COMPLETED BY APPLICANT						
Last Name:		First:	MI:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:	Are you able to wheel carts to the curb for collection? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you the legal property owner? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is the property owner's name?			Property Owner Contact Phone: ()	
Street Address:			Home Phone Number: ()		Mobile Phone Number: ()	
Mailing Address:			City, Town, Village:	State:	ZIP Code:	
<p>I, the undersigned applicant, certify that I am <input type="checkbox"/> permanently OR <input type="checkbox"/> temporarily disabled and unable to wheel my garbage and recycling carts to the curb for collection. 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 get my carts to the curb. I authorize my physician to release any information necessary to verify my disability.</p>						
Applicant's Signature				Date		

PART B: TO BE COMPLETED BY PHYSICIAN					
Physician Name:		Physician Type:		License Number:	
Physician Address:		City, Town, Village:	State:	ZIP Code:	
Physician Telephone Number: ()	Physician Fax Number: ()		Physician Email:		
<p>Note to Physician: <i>By completing and signing this form, you are indicating that it is harmful or impractical for the patient / applicant named above to use these specifically required 48, 65, or 95-gallon wheeled carts for the collection of garbage and recycling due to his or her physical condition or medical problem.</i></p>					
Is the applicant your patient?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<p>Physician statement & request for exemption. <i>Describe how use of the wheeled garbage and recycling carts would be harmful or impractical for your patient to use. Include the specific reason you believe Walk-Up Service is necessary.</i></p>					
This exemption should be:		<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary until	(month)	(year)

I certify by my signature that I am a physician licensed to practice medicine in Wisconsin, and that in my judgment the patient named above should be granted Walk-Up Service for Garbage & Recycling as described in this request.

Physician Signature		Date
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