Physician's Statement for Back Door Service Form (Please Print:)

For medical reason(s) my patient _____ is unable to and should not move their refuse cart to the curb each week. I have checked the current status of my patient – either permanently disabled or temporarily disable. If temporarily disabled, I have also indicated how long my patient will need back door service provided to them.

☐ Permanently Disabled

☐ Temporarily Disabled

Ending Date for Back Door Service for Temporarily Disabled Patient: _____

Physician's Name: _____

Physician's Address: _____

Physician's Signature: _____

For Public Works Department Office Only:

Resident's Request for Service Form Submitted and Complete: _____

Physician's Statement for Back Door Service Submitted and Complete: _____

Date Office Received Forms: _____

☐ Approved

☐ Not Approved

Reason for Not Approved: _____