Application for Backdoor Collection Service

Residents Statement

(TO BE COMPLETED BY RESIDENT REQUESTING SERVICE)

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
In accordance with the medical provider’s verification below, I state that I am physically unable to transport my household refuse and recycling to the curb for collection. I further verify that there is no person residing at my residence who is capable of transporting my rollout carts to the curb for collection.

Resident’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have any questions, please call (252) 793-5823. Return this form to the County Manager’s Office at 116 Adams St. Plymouth, North Carolina 27962 or by mail via PO BOX 1007 Plymouth, NC 27962.

Medical Provider’s Statement and Verification

(TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER)

It is my professional opinion that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (applicant) is physically unable to transport their household refuse to the curb for collection.

\_\_\_\_\_\_ It is my professional opinion that the applicant’s inability is permanent. This recommendation is

based on my personal examination and diagnosis of the applicant.

\_\_\_\_\_\_ It is my professional opinion that the applicant’s inability is temporary.

The temporary inability is anticipated to end \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Medical Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LICENSE ID NO. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_