



BACKDOOR DISABILITY COLLECTION EXEMPTION APPLICATION

HEALTH CARE PROVIDER CERTIFICATION:

I certify that Mr. /Mrs. /Ms. (please print) _____ has a disability which significantly limits his/her ability to deliver solid waste to the curbside. The foregoing statement is true, correct, and complete to the best of my knowledge and my professional belief.

Signature
(Physician, Physician Assistant, Nurse Practitioner)

Date

Print Name

Date

CUSTOMER CERTIFICATION:

I, (print name) _____ residing at (Property Address)

_____ hereby attest that I am unable to deliver my own solid waste to the curbside. I understand that by signing below, I am authorizing the waste hauler to enter my private property to collect my residential waste from my back door at each regularly scheduled pickup.

Signature _____ Date _____

Daytime Contact # (_____) _____

*Please email completed form to sanitation@newnanga.gov *