



Department of Public Works

Streets Division

1501 W. Badger Rd.
Madison, WI 53713
Fax: (608) 267-1120

Application for Residential Disabled Roll-Out Service

APPLICANT INFORMATION

Name: _____

Residential Address: _____

Zip Code: _____ Phone Number: _____

Applicant's Verification of Disability and Household Occupancy

I, the undersigned applicant, certify that I am ☐ temporarily / ☐ permanently disabled and unable to push my recycling/refuse cart 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 party that is able to get my carts to the curb.

I understand that it is my responsibility to re-submit this form annually from this date for continuance of residential disabled roll-out service.

I authorize my physician or optometrist to release any information necessary to verify my disability.

Signature of Applicant: _____ Date: _____

Disability Statement

To be completed by a Licensed Physician (or Optometrist if Applicant is legally blind)

I, a licensed physician or optometrist, hereby certify that _____
is currently disabled and unable to move their recycling and trash carts to the curb for collection.

I further certify that this disability is either:

- ☐ temporary, and the length of the disability will be from _____ to _____
☐ permanent

Name of Physician or Optometrist: _____

Address: _____

Phone: _____

Signature: _____ Date: _____