MEDICAL DOCUMENTATION FOR EXEMPTION SERVICES

These are special services provided to residents who are disabled or physically unable to place their refuse at the designated point of collection and/or are unable to shovel snow out of their driveway approach and do not have any available relative, friend or neighbor who can perform these tasks for them. While the City of Akron is able to provide these services, we must limit its availability to those whose mobility is medically and physically impaired.

Residents requesting these services must complete the Exemption Questionnaire section on this form and have their doctor complete and sign the Doctor's Certification for Exemption Services section prior to receiving these services.

EXEMPTION QUESTIONNAIRE
(To Be Completed By the Resident)

NAME: _____TODAY'S DATE: _____

CURRENT ADDRESS: _____ ZIP CODE: _____

PHONE NUMBER: _____ BEST TIME OF DAY TO CALL: _____

AGE: _____ NUMBER LIVING IN HOUSEHOLD: _____

AGES OF ADDITIONAL PERSON(S) LIVING IN HOUSEHOLD: _____

INDICATE THE SERVICE(S) YOU ARE REQUESTING:

☐ SNOW REMOVAL FROM DRIVEWAY APPROACH ☐ TRASH COLLECTION ☐ RECYCLE COLLECTION

I hereby give consent to my physician to release information to the Sanitation Division about my condition.

Resident's Name _____

Resident's Signature _____

Address _____ Zip Code _____

DOCTOR'S CERTIFICATION FOR EXEMPTION SERVICES

Medical documentation is required to verify the need of each resident who requests exemption services. Please fill out this section on behalf of your patient who is currently requesting these services. Your cooperation in this matter is greatly appreciated.

I hereby certify that _____ is under my care for the treatment of _____, which impairs mobility and physically restricts the patient from either placing their refuse at the designated point of collection and/or shoveling snow from their driveway approach.

Indicate below the service(s) your patient should be restricted from performing:

☐ Snow Removal from Driveway Approach ☐ Trash / Recycle Collection

_____ _____
Physician's Name Physician's Signature

Date _____

WHEN COMPLETED BY RESIDENT AND DOCTOR SEND TO:
Bureau of Public Works, Sanitation Division
1436 Triplett Boulevard, Akron, OH 44306