

City of Edinburg
Department of Solid Waste Management

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MEDICAL/PHYSICAL DISABILITY VERIFICATION FORM
Residential Collection/Recycling Curbside
Program

As a participant in the City of Edinburg Department of Solid Waste Management Collection/ Recycling Curbside Program, citizens are required to place all household garbage generated at the residence into a City owned and provided "plastic cart" (the "plastic cart" has a capacity of approximately 96 gallons). In addition, the "plastic cart" must be placed at the curbside of the nearest public or private road/street/highway on the specified day of collection. Citizens with a verifiable medical or physical disability that prevents them from meeting these requirements may submit a completed Medical/Physical Disability Verification Form to the Director of Solid Waste Management to request a waiver of the curbside requirement. With an approved waiver, the City will collect the "plastic cart" containing household garbage from a designated location adjacent to the house at the curbside rate.

Applicant Information

Last Name	First Name	M. I.

Street Address		

City	State	Zip

Daytime Telephone #	Evening Telephone #	

By signing below, I declare that:

- I am eligible for physical collection of household garbage due to a medical or physical disability that prevents me from placing my household garbage at the curb for collection, and
- That no other resident at the above listed address is reasonably able or expected to satisfy the requirement of placing this household garbage at the curb.

Signature	Date

Signature of Notary	Date

My commission expires: _____	

Physician Information

To be completed by Physician

This certifies that:

- I am familiar with the physical requirements necessary for the above named to place her/his roll cart at the curb, and
- I have completed a medical examination of the above named individual, and
- I, based on my medical training, have determined that she/he is unable to meet those requirements because of a medical or physical disability.

Signature Date		

Print Name	Professional License Number	

Address		

City	State	Zip

Telephone #	FAX #	

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SWM Office Use Only

Date Received at SWM	Follow up by	Date Approved

Signed	Date	