Lexington County Solid Waste Management
Lee McIntyre, Director
498 Landfill Lane
Lexington, SC 29073-7831
Phone 803-755-3325
Fax 803-755-3833

MEDICAL/PHYSICAL DISABILITY VERIFICATION FORM

Franchise Curbside Collection Program

As a participant in the Lexington County Solid Waste Management Franchise Curbside Collection Program, citizens are required to put household garbage and recyclables generated at the residence into a company provided "roll carts" (each "roll cart" has a capacity of approximately 95 gallons). In addition, the "roll carts" must be placed at the curbside of the nearest public or private road/street/highway on the specified collection day. 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 Franchise Service Provider will collect the "roll carts" containing household garbage and recycling materials from a designated location adjacent to the house but not more than 150 feet from the nearest public or private road/street/highway on the specified collection day, at the curbside rate. Recycling pick up is not available in "rural areas" within Franchise Districts 5 and 6.

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 back yard 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
  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.

Applicant Signature Date

Signature of Notary Date

Date my commission expires:

Physician Information

(To be completed by Physician)

This is to certify that:
I am familiar with the physical requirements necessary for the named individual on this form to place her/his roll cart at the curb, and
I have completed a medical examination of the 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

Physician Printed Name

Professional License Number

Street Address

City State Zip

Telephone # FAX #

SWM OFFICE USE ONLY

Date Received By SWM Follow Up By Date Approved Date Disapproved

Franchise Service Provider Area Number Date Notified

Signed **Dated** **Date Applicant Notified**