

Dear Resident(s):

Thank you for contacting the Division of Refuse Collection regarding Exemption Service. This service is to provide residents who are medically disabled or physically unable to dispose of their refuse, and **do not have a family member or neighbor who can assist them.**

To apply for Exemption Service, please **complete** the enclosed questionnaire form and sign the consent to release information on the medical documentation form. Your physician **must** complete the bottom portion of the medical documentation form in its entirety; **just a signature will not qualify for this service.** This information remains confidential and is only used in determining your eligibility for Exemption Service. Please **return both forms** to the Division of Refuse Collection in the pre-addressed return envelope.

**All members** of your household must complete a medical documentation form in order for the residence to be approved for exemption service. If additional forms are needed, please contact the 311 Service Center to have copies mailed to you.

You will be notified in writing within fifteen (15) working days upon receipt of the forms, to inform you if your application was approved.

Sincerely,



Michael Pickard  
Operations Manager  
Division of Refuse Collection

MAP: mab



**MEDICAL DOCUMENTATION FOR EXEMPTION SERVICE**

The Division of Refuse Collection provides a special service to residents who are disabled or physically unable to place their refuse at the designated point of collection. Your patient has requested this service.

Many residents inform us they are physically unable to lift or carry a refuse container or bag to the curb or alley line, or they are unable to use the 300- or 90-gallon container placed in their area. In addition, they **do not** have any available relative, friend or neighbor who can perform this task for them. While we are happy to provide this service, **we must limit its availability to those whose mobility is medically and physically impaired.**

We request that medical documentation be provided to verify the need of **each** resident who receives exemption service. Please fill out the lower portion of this letter, **in its entirety**, on behalf of your patient who has applied to receive this service. Your cooperation in this matter is greatly appreciated.

Sincerely,



Michael Pickard  
Operations Manager  
Division of Refuse Collection

**Mail to:**

Division of Refuse Collection  
Exemption Service  
2100 Alum Creek Drive  
Columbus, OH 43207

I hereby give consent to my physician to release information to the Division of Refuse Collection about my condition.

Print Resident's Name: \_\_\_\_\_

\_\_\_\_\_  
Resident's Signature

Address: \_\_\_\_\_

\_\_\_\_\_  
E-mail Address

Zip Code (**only**): \_\_\_\_\_ (city & state not necessary)

**Doctor's Certification for Exemption Service**

**(must be completely filled out by the doctor, just a signature will not qualify for exemption service)**

I hereby certify that \_\_\_\_\_ is under my care **for the treatment of**  
PRINT PATIENT'S NAME

\_\_\_\_\_ which impairs mobility and physically restricts the patient from placing their refuse at the designated point of collection.

\_\_\_\_\_  
Print Physician's Name or Add Stamp

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date



DIVISION OF REFUSE COLLECTION  
**EXEMPTION SERVICE QUESTIONNAIRE**  
(To be completed by the resident. Please answer **ALL** the questions)

NAME: Mr./Mrs./Ms./Miss \_\_\_\_\_  
(circle one)

CURRENT ADDRESS: \_\_\_\_\_

ZIP: \_\_\_\_\_ NEAREST CROSS STREET: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ BEST TIME OF DAY TO CALL: \_\_\_\_\_

RESIDENT'S AGE: \_\_\_\_\_ NUMBER LIVING IN HOUSEHOLD: \_\_\_\_\_

AGE(S) OF **ALL** ADDITIONAL PERSON(S) LIVING IN HOUSEHOLD: \_\_\_\_\_

ADDITIONAL RESIDENT NAME: Mr./Mrs./Ms./Miss \_\_\_\_\_  
(circle one)

ADDITIONAL RESIDENT NAME: Mr./Mrs./Ms./Miss \_\_\_\_\_  
(circle one)

TYPE OF SERVICE BEING REQUESTED: **REFUSE ONLY**  or **REFUSE & RECYCLING**

TYPE OF CITY COLLECTION SERVICE USED IN YOUR AREA:

96-GALLON CONTAINER (Curb Collection)  or 300-GALLON CONTAINER (Alley Collection)

DO YOU HAVE A FRIEND, NEIGHBOR, OR RELATIVE WHO IS WILLING TO PLACE YOUR REFUSE AT THE DESIGNATED POINT OF COLLECTION? YES \_\_\_\_\_ NO \_\_\_\_\_

WHO CURRENTLY PLACES YOUR REFUSE OUT FOR COLLECTION? \_\_\_\_\_

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE FOR A CHRONIC ILLNESS THAT IMPAIRS YOUR MOBILITY? YES \_\_\_\_\_ NO \_\_\_\_\_

DO YOU NEED THE ASSISTANCE OF AN AID IN YOUR MOBILITY? NO \_\_\_\_\_ YES \_\_\_\_\_

IF **YES**, WHAT TYPE: WHEELCHAIR \_\_\_\_\_ WALKER \_\_\_\_\_ CANE \_\_\_\_\_

REASON FOR REQUESTING EXEMPTION SERVICE & INFORMATION REGARDING OTHERS LIVING IN HOUSEHOLD: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

**PLEASE ATTACH THE MEDICAL CERTIFICATION FORM** and return to:

Division of Refuse Collection  
Exemption Service  
2100 Alum Creek Drive  
Columbus, OH 43207