Reset Form

# CITY OF NEWPORT NEWS

## DEPARTMENT OF PUBLIC WORKS

### Certification of Eligibility for Aged & Disabled Refuse/Recycling Collection

This application applies only to those households where *no adult* living in the home is physically able to take the refuse/recycling containers to the street for collection by the City.

I hereby certify that in accordance with Section 19-54(d) of the Newport News City Code, ***all*** adult occupants in my household are physically incapacitated to the extent that it is not possible to comply with the requirement for placing garbage/recycling containers at curbside for collection. A doctor's certificate stating that ***all*** occupants are incapable of placing refuse and recycling containers at curbside is required. Being eligible under this ordinance, I am requesting special collection services.

**Applicant's Information:**

Last Name: _____ First Name : _____ Age: _____

Address: _____ City, State _____ Zip: _____

Telephone # _____ (Home) _____ (Cellular)

**Information about other person(s) living at the same address:**

1) Last Name _____ First Name _____ Age: _____

2) Last Name _____ First Name _____ Age: _____

3) Last Name _____ First Name _____ Age: _____

4) Last Name _____ First Name _____ Age: _____

I understand it is the City's intention to investigate the information furnished.

Signed:_____ Date:_____

Approved ☐

Denied ☐

_____

City Official Signature

For additional program information, please call (757) 933-2311.

ACCREDITED AGENCY SINCE 2003

**513 Oyster Point Road, Newport News, VA 23602**

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**GENERAL MEDICAL REPORT:** To expedite the processing of request for special collection services for your patient, the City of Newport News, Department of Public Works, Solid Waste Division seeks your assistance in verifying medical information so that a determination may be made.

| **PART 1. APPLICANT / PATIENT INFORMATION** | | | | | |
|---|---|---|---|---|---|
| Last Name | | First | | M.I. | |
| Home Address: | | | | Apartment/Unit # | |
| City: | | State: | | ZIP | |
| Phone: | | Date of Birth: | | | |
| Gender: | ☐ Male ☐ Female | Date of Examination: | | | |
| **SIGNATURE OF APPLICANT:** | | | | | |

| **PART 2. CLINICAL EVALUATION:** | |
|---|---|
| | |
| Prognosis: | |
| Findings: | |

Based on my medical findings, the patient is

☐ ***Permanently*** unable to engage in any substantial gainful activity because of physical or mental condition, which is expected to continue for the duration of patient's life.

☐ ***Temporarily*** unable to engage in any substantial gainful activity due to physical or mental condition until _____ / _____ / _____.

**PART 3. PHYSICIAN INFORMATION:**

I, the undersigned, am licensed by the Department of Health Professions, in the Commonwealth of Virginia, as a health care professional. I certify that my answers are true and complete to the best of my knowledge.

| | |
|---|---|
| | Date: |
| Signature of Physician | |
| Address: | |
| Phone | |
| Name of Practice or Health Department | |

Please return the completed document to:

Dept. of Public Works
Solid Waste Division
Attn: P. Vaughn
513 Oyster Point Rd
Newport News, VA 23602