

Carrier Container Company, LLC
APPLICATION FOR SOLID WASTECART ASSISTANCE PROGRAM

Mail Completed Form to: Carrier Container Company, LLC, 24748 245th ST, Onawa, IA 51040

Resident's Statement (please print)

Name: _____

Address: _____

Telephone Number: _____

My reason for needing assistance is (check one):

I have a permanent physical condition.

I have a temporary physical condition until _____

I understand that after this date, I will be removed from the Cart Assistance Program.

I understand the Solid Waste Cart Assistance Program is provided to resident who physically unable to maneuver the garbage cart and there are no residents over the age of 12 living at the residence capable of setting out the carts. The program does not provide assistance for bulky waste service. I also understand that this service may be revoked at any time by Carrier Container Company, LLC if I no longer qualify for assistance. This determination may be made based on observations by City Staff or Carrier Container Company, LLC.

Signature: _____ **Date:** _____

Doctor's Certification:

I, the undersigned, hereby certify that I am a medical doctor licensed to practice medicine. I further certify that this patient has an ongoing medical condition that prevents him/her from moving the garbage cart to the curb for collection.

Patient's Name: _____

Doctor's Name: _____

Clinic/ Facility: _____

Address: _____

Phone Number: _____

Doctors Signature: _____

CARRIER CONTAINER COMPANY, LLC USE ONLY

Date Received: _____ **Date Customer Contacted:** _____ **Effective Date:** _____

Approved **Not Approved** **Reason:** _____