



## SPECIAL SANITATION SERVICES REQUEST

Meaning the resident is unable to push a roll-out cart to the street for service.

*A City approved rollout container must be obtained prior to Special Sanitation Services beginning.*

This application must be renewed yearly to maintain your special services.

### Part 1 - To be completed by the applicant (Please print or type)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Telephone Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Does anyone live with you? **YES or NO** If **YES** – please explain: \_\_\_\_\_

Do you have regular visitors who could take your cart to the curb? **YES or NO**

*I hereby certify that the information provided above as well as the information provided by me to the authorized physician is true and correct.*

Applicant's Signature: \_\_\_\_\_

### Part II – To be completed by a licensed Physician (Please print or type)

Physician's Name: \_\_\_\_\_

Physician's Address: (please stamp if you have one) \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Patient's disability can be described as \_\_\_\_\_

\_\_\_\_\_

Does this disability warrant this type of Special Services: **YES or NO**

Is this disability **Temporary**? If **YES** - Approximate expected duration until \_\_\_/\_\_\_/\_\_\_

*Due to the disability indicated above, I hereby certify that the applicant is unable to push a roll-out cart to the street and requires this Special Sanitation Service.*

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

**Return application to:**  
Public Works Department  
1500 Beatty St Greenville, NC 27834  
**Fax: 252-329-4535**

### Office Use Only:

Received by: \_\_\_\_\_ Date: \_\_\_\_\_ Placard Affixed: \_\_\_\_\_

Scanned: \_\_\_\_\_ Emailed: \_\_\_\_\_ Sanitation Superintendent: \_\_\_\_\_