
# Medical Pick-Up Service Application

When feasible, Kimble Recycling & Disposal Inc. ("Kimble"), the contractor that has been granted a franchise by the City of Avon Lake, Ohio for the collection of solid waste, recycling and yard waste services, provides a special Medical Pick-Up service to residents who are disabled or physically unable to place their solid waste and recycling at the designated point of collection. While Kimble is able to provide this service in certain circumstances, we must limit its availability to those whose mobility is medically and physically impaired as provided in O.R.C. Section 4503.44(A)(1). One application is required for each person in the household. To begin service, each household member should complete the "Resident's Certification for Medical Pick-Up Exemption" section of this form below. Each resident's physician should then complete the "Physician's Certification for Medical Pick-Up Exemption" portion confirming that the resident has a condition that prevents him/her from bringing his/her solid waste and recycling to the curbside pick-up location in accordance with O.R.C. Section 4503.44(A)(1).

Please note, residents utilizing medical pick-up service will be restricted to **two bags of trash or one trash cart and one recycle cart per week for the household**. Trash bags or trash and/or recycle carts must be placed at the front of the garage or front door area of the home the evening before their day of collection. Please note that, even with a certification, this service may not be available for certain addresses. Residents are responsible for keeping walkways and driveways clear in order to receive this service. Please return this completed and signed form to:

Kimble Recycling & Disposal Inc.
3596 State Route 39 NW
P.O. Box 448
Dover, Ohio 44622
Attention: Customer Service
You may also e-mail your completed application to customerservice@kimblecompanies.com.

You will be provided with a phone call confirming your entry in the program and potential approval.

## PROPERTY OWNER/RESIDENT'S CERTIFICATION FOR MEDICAL PICK-UP EXEMPTION

*(To Be Completed by the Resident-All Fields Require an Answer)*

***Please check***: □ *I certify that I have no available relative, friend, or neighbor who is willing to perform these tasks on my behalf. I hereby request Residential Waste Collection Medical Pick-Up Service. I give consent to my physician to release information to the City of Avon Lake, Lorain County, about my condition and to confirm I satisfy the requirements of O.R.C. Section 4503.44(A)(1). This certification is made with the understanding that any false statement may constitute theft of services, a prosecutable offense.*

Property Owner/Resident: _____ Kimble Account #: _____

Property Address: _____ Phone Number: _____

Email Address: _____ Today's Date: _____

Number of Persons Living in Household (Required Answer): _____

**Certification of disability is required for all persons 12 years of age or older living in the household.**

**Property Owner/Resident Signature: _____**

# City of Avon Lake Residential Waste Collection
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## PHYSICIAN'S CERTIFICATION FOR MEDICAL PICK-UP EXEMPTION

*(To Be Completed by Resident's Physician-All Fields Require an Answer)*

Documentation is required to verify the need of each resident who requests exemption services. Please fill out this section on behalf of your patient who is currently requesting these services. This certification is made with the understanding that any false statement may constitute theft of services, a prosecutable offense. Your cooperation in this matter is greatly appreciated.

I hereby certify that_____(please print name) is under my care, **and is a "person with a disability that limits or impairs the ability to walk" as defined in O.R.C. Section 4503.44(A)(1).** I hereby request that the City of Avon, Lorain County Lake Residential Waste Collection program perform a special medical pick-up for my patient.

Physician's name: _____
(please print clearly)

Practice Name/Affiliation: _____

Office Address (Street, City, State and Zip): _____

Telephone Number (incl area code): _____

Physician's Signature: _____

Today's Date: _____

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**FOR KIMBLE USE ONLY**

Approved

Not Approved

Application Reviewed By:_____

Application Reviewed Date:_____

*Comments.:* _____