DISABILITY CERTIFICATION

Duration: ☐ Temporary ☐ Permanent

Type of Waste: ☐ Trash Only ☐ Trash and Recycling

Name: _____

Street Address: _____

City: Sioux City State: Iowa Zip: _____

Phone Number: _____ Email: _____

Account Number: _____

Regular Pick-up Day: _____

PHYSICIAN'S STATEMENT: The above resident has been under my care and is unable to place bags, bundles or containers of refuse at the curb for collection.

If temporary, disability will terminate on the following date:

Physicians Name: _____

Physicians Signature: _____

Date: _____

Physician's Phone Number: _____

RESIDENT'S STATEMENT AND AUTHORIZATION: In accordance with the contract provisions of Gill Hauling, Inc. (A subsidiary of Waste Connections) I hereby certify that I am unable to place bags, bundles or containers of refuse at the curb for collection and there is no one at the residence who can do so. I authorize my physician to verify this statement to Gill Hauling. I waive and release Gill Hauling from any and all claims for damages to pavement or driving surface resulting from Gill Hauling trucks or employees use of such pavement or driving surface to ingress and egress to and from solid waste containers located upon my property.

Resident Signature: _____ **Date:** _____

PLEASE HAVE PHYSICIAN'S OFFICE FAX OR EMAIL COMPLETED FORM TO THE FOLLOWING FAX 402-587-6122 OR EMAIL OLP3134@WASTECONNECTIONS.COM or mail to Gill Hauling at PO Box 885, South Sioux City, NE 68776