Solid Waste-Backdoor Handicap Physician Form

ALL APPLICANTS MUST SUBMIT A NEW FORM EACH YEAR

For Calendar year Jan-Dec

Date: _____ Date of Birth: _____

Name: _____ Telephone #: _____

Address: _____ Apt # _____

My signature below gives permission for my Healthcare provider to share medical information with the City of Brunswick for use of qualifying for the Backdoor Handicap program only. I also certify that there is no one in my household or employ that is able to carry my garbage/recycling to the curb.

_____
Signature

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The person listed above has a medical-disabled/handicapped condition that prevents the above named person from taking their garbage to the curbside. Please accept my signature below as my recommendation that the above named person receive Backdoor Handicap Service.

_____ _____
Physician Print Name License #

_____ _____
Address Phone #

_____ _____
Physician Signature Date

The information received will only be used to determine the eligibility of the person above to participate in the Solid Waste Backdoor Program. The City of Brunswick does not share the information in compliance with HIPPA (Healthcare Information Privacy Portability Act of 2003).

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