APPLICATION FOR RESIDENTIAL DISABLED CARRYOUT SERVICE
CITY OF FORT WORTH
CODE COMPLIANCE DEPARTMENT, SOLID WASTE SERVICES DIVISION
4100 COLUMBUS TRAIL, FORT WORTH, TX 76133

APPLICANT INFORMATION

Name: ____________________________________________________________

Residential Address: ________________________________________________________________

Fort Worth, TX Zip: ___________________________ Telephone No.: ___________________________

Water Account Information—Customer No.: ___________________________ Location ID No.: ___________________________

Disabled Carryout Information: □ Front Porch □ Other: __________________________________________

APPLICANT’S VERIFICATION OF DISABILITY AND HOUSEHOLD OCCUPANCY
To be completed by Applicant

I, the undersigned applicant, certify that I am □ temporarily □ permanently disabled and unable to carry my
residential garbage/recycling to the curb. I also certify that there is no one in my household or employ that is able to
carry my garbage/recycling to the curb.

I understand that it is my responsibility to re-submit this form annually from this date for continuance of residential
disabled carryout service.

I authorize my physician or optometrist to release any information necessary to verify my disability.

Signature of Applicant: ___________________________________________ Date: ________________

DISABILITY STATEMENT
To be completed by a Licensed Physician (or Optometrist if person is legally blind)

I, a licensed physician or optometrist, hereby certify that _______________________________________________________
is currently “disabled” as described below and unable to carry his/her garbage/recycling to the curb.

Nature of disability: _________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

I further certify that such disability is of a: □ temporary nature
(Length of Disability is from ______________ to ______________)
□ permanent nature continuing for the applicant’s lifetime

Name of Physician or Optometrist: ______________________________________________________

Professional License Number: __________________________________________ Telephone Number: ________________

Address: __________________________________________ City/State/Zip: __________________________

Signature of Physician or Optometrist: __________________________________________ Date: ________________