

DISABLED ON-PREMISE APPLICATION

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| Applicant's Name and Address | Provide bill/mailling address if it is different from the service address. | CITY USE ONLY Account Number: Case #: |
|------------------------------|--|--|

On-Premise service is provided for individuals who are unable to move their garbage, recycling and yard trimmings carts to the curb for collection. In order to qualify, there must be no other residents in the home physically able to move the carts to the curb for collection. This service is provided at no extra cost to eligible residents. Please complete the information below. A medical doctor licensed to practice in the State of California must certify this form.

| | | | | | |
|---|--|----|--|-----|----|
| Daytime Telephone Number(s) | Where on your Property, are the carts located for pick-up? | | | | |
| Owner or Care Provider Name & Address | Name of Townhome/Condominium Complex or Mobile Home Park | | | | |
| Telephone Number | Telephone Number | | | | |
| Number of people in the household Adult(s) Child(ren) | Would you like a yard-trimming cart at no cost? | NO | | YES | |
| | If yes, make cart size selection | 32 | | 64 | 96 |

DOCTOR'S CERTIFICATION

I, the undersigned, hereby certify that I am a medical doctor licensed to practice medicine in the State of California. I further certify that my patient named below has an ongoing physical disability that prevents him/her from moving the garbage, recycling, and/or yard trimmings carts to the curb for collection.

| | | | | | |
|--------------------|-------------------------|------------|--|------------|--|
| Patient's Name | Doctor's License Number | | | | |
| | | | | | |
| Doctor's Signature | Date | Print Name | | | |
| | | | | | |
| Business Address | Telephone Number | | | Fax Number | |
| | | | | | |

APPLICANT'S CERTIFICATION

I certify that there is no capable person living in the house to move the garbage cart, recycling cart and yard trimmings cart to the curb for collection. I authorize the changes to be made to my garbage service, and agree to have my eligibility verified at the request of the City of San José. I will notify Customer Contact Center of any changes in my physical condition or to my household members. Under penalty of perjury, I declare that all information on this application is true, correct and complete. I understand the submission of false documentation will result in financial liability for the full subscription price for services granted from date of original approval.

| | | | | | | | |
|-----------------------|---------------|-------------|-------------|------------|------------|----------|----------------|
| Applicant's Signature | | | | Print Name | | | Date |
| CITY USE ONLY | Approved date | Approved by | Denial date | Denied by | Delay Date | Delay by | Effective date |