



**Return completed form to:  
CITY OF WAUSAU CUSTOMER SERVICE  
407 GRANT STREET WAUSAU WI 54403 FAX 715-261-0319**

**Application for Residential Disabled Roll Out Service  
Applicant Information**

Name: \_\_\_\_\_

Residential Address: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Applicant's Verification of Disability and Household Occupancy**

I, the undersigned applicant, certify that I am \_\_\_\_ temporarily \_\_\_\_ permanently disabled and unable to push my recycling./refuse cart to the curb. I also certify that there is no one in my household, in my employ, or providing in home assistance to me from a third party that is able to get my carts to the curb. I understand that it is my responsibility to re-submit this form annually from this date for continuance of residential disabled roll out 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 Applicant is legally blind)**

I, a licensed physician or optometrist, hereby certify that \_\_\_\_\_  
is currently disabled as described below and unable to get his/her recycling/refuse carts to curb.

Nature of disability:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I further certify that this disability is temporary in nature (Length of disability is from \_\_\_\_\_ to \_\_\_\_\_) or is \_\_\_\_ permanent nature continuing for the applicant's lifetime.

Name of Physician or Optometrist:

\_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_