CITY OF HARDINSBURG

EQUAL OPPORTUNITY PROVIDER

220 SOUTH MAIN ST • PO BOX 149 • HARDINSBURG KY 40143-0149
PHONE: 270.756.2213 • FAX: 270.756.2029 • MUNICIPAL UTILITY FAX: 270.756.2863

PHYSICIAN'S ASSISTED SERVICE CERTIFICATION

Applicant Instructions: Please fill-in your contact information, sign your certification of need for assistance and give the form to your physician to complete. Assisted service will begin once we receive the certification from your physician.

Applicant Name: _____
Applicant Address: _____
_____
_____
Applicant Phone #: _____

Applicant Certification: In order to protect the integrity of the Assisted Service Sanitation Program, I certify that I am unable to take my mobile cart to the curb for collection. **I further certify that no one else lives in my household who is able to bring the mobile cart to the street.** I give my consent for my physician to release the below requested information to the Hardinsburg Sanitation Department.

Applicant Signature _____

Physician Instructions: The above named patient has applied for assisted sanitation service and has authorized you to release the below requested information to our office for processing the request. In order to qualify for assisted service, the applicant must be physically or mentally unable to push their wheeled-mobile-cart to and from the curb for collection. Please fill-in your contact information, check the block/blocks indicating the patients' limitation, sign the certification and return to our office at the above address/fax.

Physician Name: _____
Office Address: _____
_____
_____
Office Phone: _____

Physician Certification: My judgment is that my patient is unable to bring their mobile cart to the street for weekly or bi-weekly service due to (check one):

❑ Difficulty negotiation a flight of stairs ❑ Use of wheelchair or walker
❑ Difficulty in walking more than 100 feet ❑ Current mental condition
❑ Difficulty in lifting more than 20 pounds ❑ other

If this condition is temporary (e.g. broken bone, surgery), when do you expect this assisted service to no longer be necessary? _____. Please mail/fax to the above address/fax number; service may not begin without this certification.

Office Use Only
Access_____
AS400 _____
Driver _____

Physician Signature: _____

Date: _____

"HEARING OR SPEECH IMPAIRED, OR DEAF USERS MAY CALL
KENTUCKY RELAY SERVICE 800.648.6056.
Give the Communications Assistant our phone number to contact us."