

**CITY OF SUGAR LAND  
PUBLIC WORKS DEPARTMENT  
APPLICATION FOR SOLID WASTE CART ASSISTANCE PROGRAM**

**Mail completed form to:**

**City of Sugar Land, Public Works Department, P.O. Box 110, Sugar Land, Texas 77487-0110.**

**Resident's Statement** (please print):

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

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Subdivision: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**My reason for needing assistance is (check one):**

- I have a permanent physical condition.
- I have a temporary physical condition until \_\_\_\_\_.

I understand that after this date, I will be removed from the Cart Assistance Program.

I understand the Solid Waste Cart Assistance Program is provided to residents who are physically unable to maneuver the garbage and recycle carts and there are no residents over the age of 12 living at the residence that are capable of setting out the carts. The program does not provide assistance for green waste or bulky waste service. I also understand that this service may be revoked at any time by the Public Works Department if I no longer qualify for assistance. This determination may be made based on observations by City staff or Republic Services operations staff.

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

**Doctor's Certification:**

I, the undersigned, hereby certify that I am a medical doctor licensed to practice medicine in the State of Texas. I further certify that this patient has an ongoing medical condition that prevents him/her from moving the garbage and recycle carts to the curb for collection.

Patient's Name	
Doctor's Name and Degree	
Clinic/Facility Name Address City, State Zip Phone Number	
Doctor's Signature	Date

**FOR PUBLIC WORKS DEPARTMENT USE ONLY**

**Date Received:** \_\_\_\_\_ **Date Customer Contacted:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

**Approved**       **Not Approved Reason:** \_\_\_\_\_