CITY OF COLLEGE STATION
PUBLIC WORKS

DISABILITY SERVICE APPLICATION FOR SOLID WASTE SERVICES

Applicant Name: _____

Physical Address: _____

Phone Number: _____ **Date:** _____

Applicant's Physician/Medical Provider must complete and sign this form before service can begin.

Check one of the boxes:

☐ **Patient is temporarily disabled from** ____ / ____ / ____ **to** ___ / ____ / ____ .

☐ **Patient is permanently disabled.**

Name of Physician/Medical Provider:

Address: _____

Phone: _____

Signature: _____ **Date:** _____

Completed forms can be faxed to 979.764.3489 or emailed to **rwaller@cstx.gov.**