



City of Newport News



Department of Public Works

CERTIFICATION OF ELIGIBILITY FOR REAR YARD REFUSE/RECYCLING COLLECTION

This application applies only to those households where no one is physically able to take the refuse/recycling containers to the street for collection by the City.

I hereby certify that in accordance with Section 19-54(d) of the Newport News City Code, the sole adult occupant or occupants in my household are physically incapacitated to the extent that it is not possible to comply with the requirement for placing garbage/recycling containers at curbside for collection. A doctor's certificate stating that all occupants are incapable of placing garbage/recycling containers at curbside is required. Being eligible under this ordinance, I am requesting rear yard collection.

Applicant's Name _____ (Age) _____

Address _____ (Zip) _____

Telephone (Home) _____ Business _____

Name and age of persons living in this household:

1. _____ (Age) _____

2. _____ (Age) _____

3. _____ (Age) _____

I understand it is the City's intention to investigate the information furnished.

Signed: _____ (Date) _____

Approval:

_____ GRANTED

_____ DENIED

City Official

If you need additional information, please call 269-2874.

Accredited Agency



Since 2003

513 Oyster Point Road ■ Newport News VA 23602

Telephone: (757) 269-2700

FAX: (757) 269-2725

Email: gpubwk@nngov.com

Operational Divisions: Building Services
(757) 269-2730

Solid Waste
(757) 269-2850

Street Maintenance
(757) 269-2800

Wastewater
(757) 269-2750



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GENERAL MEDICAL CERTIFICATE FOR BACKYARD PICK-UP SERVICE

I, _____, a medical doctor licensed to practice medicine in the Commonwealth of Virginia, say that the following is true and correct to the best of my professional knowledge.

1. That I have personally physically examined _____ on the _____ day of _____, _____, independently of any other doctor.
2. That my findings were _____.
3. That my prognosis is _____.
4. That my medical determination based on the above findings and prognosis indicate that _____ is and will be unable to engage in any substantial gainful activity because of physical or mental impairment or deformity which is expected to:

(✓ check one)

_____ Last until _____.

_____ Last for the duration of the person's life.

(Signed by Doctor)

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