FOR OFFICIAL USE ONLY: Permit received: _____ Physician certification received: _____ Collection day: _____

City of North Port Solid Waste
Special Collection Service Request

In consideration of the City of North Port, Florida ("City") providing special residential solid waste collection services at the below address the undersigned hereby states and agrees as follows:

The undersigned resident ("resident") is unable to place their solid waste, recycling, and/or yard waste containers ("waste containers") at the required location due to a physical disability. There is no other person living at the address capable of placing the waste containers at the required location.

The resident hereby authorizes the City's staff or contractors to enter the address provided solely for the purpose of collecting the solid waste, recycling, and/or yard waste containers. Special collection services shall not apply to bulk waste pickup.

Attached is a copy of the resident's disabled parking permit or a signed certification from a licensed medical professional who has evaluated the resident and determined they qualify for the issuance of a disabled parking permit pursuant to the requirements identified in F.S. §320.0848 or other physical disability that prevents the resident from placing their solid waste, recycling, and/or yard waste containers at the required location.

Resident Name: _____ Disabled Parking Permit No: _____

Resident Address: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

Identify the proposed alternative location where solid waste, recycling, and/or yard waste containers shall be ready, easily accessible, and available for collection prior to the beginning of each collection day:_____
_____

BY SIGNING BELOW, THE UNDERSIGNED HEREBY WAIVES, RELEASES, AND AGREES TO INDEMNIFY, DEFEND, AND HOLD HARMLESS, THE CITY, ITS COMMISSIONERS, OFFICERS, AGENTS, AND EMPLOYEES FROM ANY CLAIM, DEMAND, LIABILITY, COST, SUIT, JUDGMENTS, DAMAGES, CHARGES OR COMPENSATION FOR LOSS OR INJURY OF ANY KIND (INCLUDING BUT NOT LIMITED TO REASONABLE ATTORNEYS' FEES AND COURT COSTS, WHETHER SUCH FEES AND COSTS ARE INCURRED IN NEGOTIATIONS, AT THE TRIAL LEVEL OR ON APPEAL, OR IN THE COLLECTION OF ATTORNEYS' FEES), ARISING OUT OF A LOSS OR AN INJURY, INCLUDING LOSSES OR INJURIES ARISING FROM ANY ACTS, ACTIONS, INACTIONS, OR NEGLIGENCE OF THE CITY, ITS COMMISSIONERS, OFFICERS, AGENTS, OR EMPLOYEES ARISING FROM THE UNDERSIGNED'S PARTICIPATION IN THE SPECIAL COLLECTION SERVICE. THE UNDERSIGNED ACKNOWLEDGES THAT THE CITY WILL NOT ASSUME ANY COSTS RELATING TO ANY INJURY OCCURRING ON THE UNDERSIGNED'S PROPERTY DURING THE UNDERSIGNED'S PARTICIPATION IN THE SPECIAL COLLECTION SERVICE. NOTHING HEREIN SHALL CONSTITUTE A WAIVER OF SOVEREIGN IMMUNITY OR CONSENT BY THE CITY OR ITS SUBDIVISIONS TO A SUIT BY THIRD PARTIES.

***** CAREFULLY READ THIS DOCUMENT BEFORE SIGNING IT. YOU ARE WAIVING OR RELEASING VALUABLE LEGAL RIGHTS. YOU ARE ADVISED TO SEEK THE ADVICE OF AN ATTORNEY IF YOU DO NOT FULLY UNDERSTAND THIS DOCUMENT. BY SIGNING THIS DOCUMENT, YOU ARE AGREEING TO ITS TERMS AND STATING THAT YOU HAVE CAREFULLY READ AND FULLY UNDERSTAND THE ABOVE, AND ARE SIGNING BY YOUR OWN FREE ACT. *****

Resident Signature: _____ Date: _____

Physician's Certification

Name of Licensed Medical Professional: _____

Medical License No: _____

Medical Office Address: _____

Medical Office Telephone: _____

Name of Resident Evaluated: _____

Check appropriate box:

☐ Resident temporarily qualifies for the issuance of a disabled parking permit pursuant to the requirements identified in Florida Statutes Section 320.0848, or temporarily has another physical disability that prevents them from placing their solid waste containers at the required location, until: _____ (provide specific date of expiration).

☐ Resident qualifies for the issuance of a disabled parking permit pursuant to the requirements identified in Florida Statutes Section 320.0848 or has another physical disability that prevents them from placing their solid waste containers at the required location.

Signature of Licensed Medical Professional: _____ Date: _____