



CITY OF SHREVEPORT
DEPARTMENT OF PUBLIC WORKS—SOLID WASTE DIVISION
1731 KINGS HWY, SHREVEPORT, LA 71103
318-673-6300 Office * 318-673-6320 Fax

RE: Application for Backdoor Garbage Collection

Dear Applicant:

You recently requested an application for Backdoor Garbage Collection service for Disabled Citizens.

The City ordinance which authorizes the change to curbside garbage service established two requirements which must be met before a disabled citizen can receive backdoor garbage service .

The City must be provided with a statement from a physician on the **Physician's Letterhead** certifying that the applicant is physically unable to carry his/her garbage to the curbside for collection.

The Applicant must complete the **Applicant's Statement** certifying that there is no one else in the household physically able to carry his/her garbage to the curbside for collection.

If you meet these requirements, please complete the enclosed application and have a Physician complete the **Physician's Statement** on the **Physician's Letterhead** and fax or mail to: City of Shreveport, Solid Waste Division, 1731 Kings Hwy., Shreveport, La. 71103.

If you have any questions, please feel free to contact me at 673-6300 or by email: **monique.brun@shreveportla.gov**

Sincerely,

Monique Bruns
Administrative Assistant
Solid Waste Division



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APPLICATION FOR BACKDOOR GARBAGE / RECYCLING COLLECTION
DISABLED CITIZENS
(Please print legibly or type)

Date: _____
Applicant's Name: _____
Applicant's Address: _____ SHREVEPORT LA _____
Phone Number: _____ Other Number: _____

APPLICANT'S STATEMENT

I hereby certify that I am the individual listed on this application, and that I am unable to carry my garbage to the curbside for collection. I further certify that there is no one residing with me who is physically able to carry my garbage to the curbside for collection.

Applicant's Signature: _____

PHYSICIAN'S STATEMENT: Permanently Disabled Temporarily Disabled Until Release Date: _____

I hereby certify that I have examined the applicant listed above, and that this individual is physically unable to carry their garbage to the curbside for collection. I have checked the box above that best describes their disability and will be able to provide any additional documentation if needed.

Physician's Name: (PRINT ONLY) _____

Office Address: _____ Shreveport, LA Zip code _____

Office Phone: _____ Fax: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

**DO NOT WRITE BELOW THIS LINE **

COLLECTION DAY _____