Confidential

Application for Financial Relief & Curbside Collection Exemptions for Medical Waste

This application is for Northumberland County Residents who have medical conditions which result in them generating excess amounts of non-hazardous waste requiring disposal.

Please complete **Page 1, 2, 3 and 4 (Amendment 2022)** and return to the Manager, Waste Operations & Resource Recovery by:

1. **Mail:** County of Northumberland, 555 Courthouse Rd., Cobourg, ON, K9A 5J6
2. **E-Mail:** wastedept@northumberland.ca

Please mark correspondence "**Confidential**"

1. Resident Information: (please print)

Last Name:________________________ First Name: ________________________

Street Address:____

Mailing Address:____

Town/City:________________________ Postal Code:________________________

Telephone Number:____________________ E-Mail (optional): ____________________

If your application is approved, you will be provided with free bag tags to affix to your extra bags of medical waste. Tags can be picked up from the County of Northumberland's Headquarters Building, located at 555 Courthouse Road., Cobourg, from 8:30 a.m. to 4:30 p.m., Monday through Friday, or the tags can be mailed directly to your home. Please indicate if you would like to pick up the tags, or have them mailed to you:

Pick up tags

Tags mailed to your home

Please note that the County of Northumberland will not be held responsible for any delay in the delivery of tags or for tags lost in the mail. Replacement tags will not be issued.

2. Description of Waste to be Generated

Please check the appropriate box to describe the waste which will be generated. If you select "Other" please provide a brief description of the waste.

Empty plastic fluid bags and plastic tubing from at-home dialysis treatment

Incontinence products (e.g. adult disposable undergarments and pads)

Other:____

Please note that the following items **cannot** be set out for curbside collection:

1. **Waste Sharps** (including: needles, syringes, blades and lancets)
2. **Human Tissue** (excluding: teeth, hair and nails)
3. **Bodily Fluids** (excluding: urine and feces)

3. Type of Assistance Required

Please indicate below the number of bag tags you will require over a 12 month period to assist you with the disposal of the waste generated as a result of your medical condition. The County reserves the right to make a final determination on the number of bag tags issued.

I will require:

26 bag tags over a 12 month period

52 bag tags over a 12 month period

Other: (please specify number required) ________

If you will need to place more than two (2) bags or containers of medical waste and residential waste out on a weekly basis, please indicate below how many bags or containers you will need to place out on a weekly basis.

The maximum number of bags or containers of garbage (including medical waste and residential waste) that I will place out for curbside collection on a weekly basis will be ________ bags or containers.

4. Terms and Conditions

I acknowledge that this allowance is for medical waste only, and that no other waste will be placed in the bag / container

I acknowledge that the tags provided to me by the County are for my sole use and will not be transferred or re-sold.

I acknowledge that participation in the County of Northumberland's Recycle Right Program is required under the Waste Management By-Law, and agree to fully participate in this program.

I am aware and acknowledge that this application must be renewed annually and that a doctor's signature must be obtained every three (3) years.

I hereby certify that the information provided here in is true and accurate.

Applicant Signature:___________________________ **Date**:_________________________

5. Certification by Physician

Note: Required every three (3) years from the initial application

Physician Name:____

Mailing Address:____

Telephone Number:____

This is to certify that the below named patient's medical condition results in the generation of medical waste which is beyond their control.

Physician Signature:__________________________ Date:__________

Patient Name:_______________________________

Notice with Respect to the Collection of Personal Information

Personal Information and Personal Health Information requested on this form is collected as a necessary part of the administration of waste management collection services by the County of Northumberland pursuant to its legal authority set out in the Municipal Act, 2001. Collection, use and confidentiality of the personal (health) information will be according to the standards in the Municipal Freedom of Information and Protection of Privacy Act or the Personal Health Information Act, 2004, and the information will be used for the purpose of verification of eligibility for specialized set out service programming only.

For further inquiries about the handling of your personal information, please contact:

The County of Northumberland
Manager, Waste Operations & Resource Recovery
555 Courthouse Road
Cobourg, ON K9A 4J6
1-866-293-8379

Amendment 2022

Please indicate if your medical condition is temporary or permanent.

☐ Temporary ☐ Permanent

Please Keep this Page for Your Records

1. If your application is approved, you may place up to ________ bags / containers of waste out for curbside collection, provided that no more than two (2) of the bags / containers contain normal household waste.

2. Each bag / container of waste set out for curbside collection must have a valid bag tag affixed to it.

3. The bag tags provided to the applicant are for use by the applicant and are not to be transferred or sold.

4. All materials (garbage and recyclables) must be at the curb by no later than 7 a.m. on your scheduled pick up day.

5. Participation in the County of Northumberland's Recycle Right program is required under the Waste Management By-law.

6. This application must be completed annually on the anniversary date for continued service. A renewal form will be sent to you prior to the expiry of this service. A physician's signature will only be required every three years. Please note below the application date for your records.
   Date of Application:______________________

7. Certification by a physician in required every three years, please note the date of physician certification below for your records.
   Date of Physician Certification:___________________