Date:

Epping Forest District Council
www.eppingforestdc.gov.uk

Civic Offices
High Street
Epping
Essex
CM16 4BZ

Our Ref:

Your Ref:

Subject: ADDITIONAL CAPACITY ON MEDICAL GROUNDS – QUESTIONNAIRE

1 Please confirm the name, address, telephone number and email address of the applicant in the space below:

Tel No: _____

2. Reasons for requesting additional capacity facilities for refuse:

_____

_____

_____

_____

We assess every case on its merits, it would assist us if you are disabled, if you provide details of the relevant number/reference e.g. blue badge scheme or visually impaired

3. Does anyone else live with you in your home? ☐ Yes ☐ No

4. Please advise as to the number of people living in the same house _____

5. Please provide information on the type and amount of waste your medical condition will create on each waste collection that cannot be recycled.

_____

_____

_____

Please ask you GP/Healthcare professional to complete Section 6 and 6 A) and B) over the page. You will also need to sign and date the section marked up as to be completed by the applicant.

6. Must be completed by your <u>Healthcare professional/GP</u> only, along with sections A) and B)

Healthcare Professional/GP Name (Please Print in Block Capitals)	

Contact Telephone Number	
Address:	Email address
Date :	**Signature of Healthcare Professional**

a) Please give full details of medical condition:

_____

_____

b) Please give full details of the type and quantity of waste that will be produced from this condition:

_____

_____

This section to be completed by the applicant:

I confirm that the information I have given is true and give my permission for the Council and its officers to carry out any necessary checks to verify the information I have given is correct. I understand the Council will treat the information I have provided s confidential and that it will not be used for any other purpose.

Signed_____ Date _____

"By signing this form you are agreeing for EFDC to share your personal information with your healthcare professional and any other third party that may need to be involved with this application."

Please note that if this form is not returned within two weeks from the date of this letter it will be assumed that you no longer require additional capacity and you will be removed from the list.

For office use

Agreed / Rejected If agreed – additional capacity details required: ☐ Litres

Comments ……..

Signed:…….. Date:..…….

Evidence Seen by …….. Date…….

Original Evidence Returned to applicant by …… Date…….