CONFIDENTIAL PATIENT WAIVER & PHYSICIAN STATEMENT

Return this form with attached physician's statement to: Sharon Adult Center/Council on Aging, 219 Massapoag Avenue, Sharon MA 02067 and mark envelope "Attention: Social Services." Call the Adult Center/COA at 781-784-8000 for more information.

Please complete this form for the Town of Sharon and return to patient or Sharon Adult Center/Council on Aging as soon as possible. *Application for this program cannot be completed without this statement.*

I, ____

(print name & address of patient)

allow my physician, Dr. ____

____

(print name and address of doctor)

to provide the information below to the Town of Sharon, Adult Center/Council on Aging. This information will be treated confidentially.

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(signature of patient)

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PHYSICIAN COMPLETE BELOW:

The above named person is requesting to be considered for the Town-sponsored refuse collection program. In order to qualify, any applicant under 60 years of age must have a disability certified by their physician. Please note any and all diagnoses and name of disability/disabilities.

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Physician's signature ***Date***

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Please print name

For more information contact the Sharon Adult Center/Council on Aging – 781-784-8000.