ENGINEERING & PUBLIC WORKS DEPARTMENT
1737 Broadway Street, Port Coquitlam, BC V3C 2M9
ph: 604.927.5496 fax: 604.927.5408 publicworks@portcoquitlam.ca

APPLICATION FOR SET OUT/SET BACK SERVICE

Bylaw No. 3900 - Schedule "A"

Please print clearly Date: _____

I, _____ as occupier of property located at
(First Name) (Last Name)

_____
(Street Number) (Street Name)

_____
(City) (Province) (Postal Code)

hereby apply for this service and agree to the following conditions:

- The occupier of this property has a physical challenge or infirmities that prevent him/her from moving the carts to the collection point and does not have an able-bodied person to help with this activity;
- Carts shall be freely accessible and not be placed inside closed buildings or gated areas;
- If an able-bodied person becomes available prior to the expiry of an approval, the applicant is required to notify the City and this service will no longer be provided;
- The City is not responsible for any damage to private property resulting from the executing of this service.

APPLICANT INFORMATION

What is the nature of the disability? _____

Is the disability permanent? ☐ Yes or ☐ No *(If yes, this application is valid for 3 years)*

If the disability is not permanent, at what date would the Applicant be sufficiently recovered?

_____/_____/_____
(Month) (Day) (Year)

_____ _____ _____
Signature of Applicant Phone Number Date

REQUIREMENTS

Please submit this form with a completed Supplemental Form for Physically Challenged Persons.

OFFICE USE ONLY ☐ Your request is DENIED ☐ Your request is APPROVED

Approved by: _____ Date: _____
Les Nerdahl, Trades & Sanitation Foreman

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SUPPLEMENTAL FORM FOR PHYSICALLY CHALLENGED PERSONS

Bylaw No. 3900 - Schedule "A"

Please print clearly Date: _____

This form is provided to physicians in order to verify that the person named below has a physical limitation that would prevent them from setting out wheeled refuse containers for collection at the location specified below.

PATIENT INFORMATION

Patient Name: _____
(First Name) (Last Name)

Patient Address: _____
(Street Number) (Street Name)

_____
(City) (Province) (Postal Code)

What is the nature of the disability? _____

_____

_____

Is the disability permanent? ☐ Yes or ☐ No

If the disability is not permanent, at what date would the Patient be sufficiently recovered?

_____/_____/_____
(Month) (Day) (Year)

Physician's Name: _____

☐ I certify that the information provided in this application is true and correct, based upon information given to me by the applicant.

_____ _____
Signature of Physician Date