



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

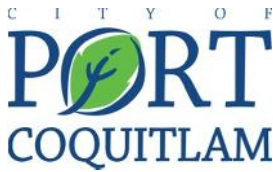
[] Your request is DENIED

[] Your request is APPROVED

Approved by: _____

Date: _____

Les Nerdahl, Trades & Sanitation Foreman



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