ENGINEERING & OPERATIONS DEPARTMENT
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SUPPLEMENTAL FORM FOR PHYSICALLY CHALLENGED PERSONS

Bylaw No. 3760 - 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