

REQUEST FOR COURTESY SNOW BERM REMOVAL FROM DRIVEWAY

(To be completed by person desiring an accommodation due to disability)

Date: _____

Name: _____

Physical Address: _____

Telephone: (Day): _____ **(Evening)** _____

Nature of Disability: _____

Is any other able bodied person living at your residence? ____ **yes** ____ **no**

Is a 4-wheel drive vehicle available for use by the applicant? ____ **yes** ____ **no**

Signature

Signature of Parent or
Guardian if Applicant is under 18

PHYSICIAN CERTIFICATION:

The applicant is a patient under my care and is physically unable to perform the act of shoveling snow.

Name and Address of Physician

Signature of Physician

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TO BE COMPLETED BY CITY STAFF:

Date Received: _____ By: _____

Application approved: ____ **yes** ____ **no**

Route Number: _____ Route Sequence: _____