

# Application for Service Level Change Medical Set-Out/Set-Back Service Form

Set-out/set-back service is where collection crews will enter your property to move solid waste collection container to the curb for collection and return it to the property.

I, \_\_\_\_\_ as the occupier of the property located at

Address \_\_\_\_\_  
(Street Number) (Street Name)

\_\_\_\_\_ (Street Number) (Province) (Postal Code)

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

- The occupier of this property has a permanent physical disability that prevents them from moving the container to and from the collection point and does not have an able-bodied person to help them with this activity.
- The occupier must provide written proof of permanent physical disability or have their doctor sign the verification of disability section.
- The container shall be freely accessible and not be placed inside closed buildings or a gated area, and there must be safe access during all seasons.
- If an able-bodied person becomes available prior to the expiry of approval, this service will no longer be provided.
- The City is not responsible for any damage to private property resulting from the execution of this service.

Applicant's information  New  Renewal

What is the nature of the disability? \_\_\_\_\_

Is the disability permanent?  Yes  No (If yes, this application is valid for three years.)

If the disability is not permanent, what date will the applicant be sufficiently recovered?

\_\_\_\_\_  
Number of persons living in the household \_\_\_\_\_

I certify that the information I have provided is true and accurate.

\_\_\_\_\_  
(Signature) (Phone Number) (Date)

# Application for Service Level Change Verification of Disability

**To be completed by an authorized medical doctor.**

I certify that my patient \_\_\_\_\_  
has a permanent physical disability and is unable to move a solid waste collection container to  
and from the collection point.

Doctor's signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's name \_\_\_\_\_

Doctor's address \_\_\_\_\_

Doctor's telephone \_\_\_\_\_

Please note that your doctor may charge for this service and that you are responsible for  
paying any costs involved in getting this information.

**Office Use Only**

Your application is approved *or*  Your application is denied

Verification of disability form received

The occupier will assist with any special designations as may be required to alert the crews that  
this type of collection service is required and comply with the following:

Date received \_\_\_\_\_ Date approved \_\_\_\_\_

\_\_\_\_\_  
Environmental Services Supervisor