CITY OF PORT ALBERNI

City Hall Engineering Department

SOLID WASTE COLLECTION AND DISPOSAL BYLAW
SCHEDULE "B" TO BYLAW NO. 4790

APPLICATION FOR SET-OUT/SET-BACK SERVICE

A. Set Out/Set Back Service

Set Out/Set Back Service in which collection crews will enter my property parcel to move solid waste collection carts to the curb for collection and return them to the property.

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

Address: _____
(Apt #) (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 cart collection point and does not have an able-bodied person to help them with this activity;
- Carts shall be freely accessible and not be placed inside closed buildings or a gated area;
- If an able-bodied person becomes available prior to the expiry of an approval, this service will no longer be provided;
- The City is not responsible for any damage to private property resulting from the undertaking of this service.

Applicant's 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? _____
(Year) (Month) (Day)

_____ _____ _____
(Signature of Applicant) (Phone Number) (Date)

OFFICE USE ONLY

☐ Your application is approved or ☐ Your application is denied

☐ Physician's Certificate required (Schedule E to be completed and returned to the City)
The occupier will assist with any special designations as may be required to alert the crews that this type of collection is required, and comply with the following:

_____

_____

Date Received: _____

Streets Superintendent: _____

CITY OF PORT ALBERNI

SOLID WASTE COLLECTION AND DISPOSAL
SCHEDULE "E"

PHYSICIAN CERTIFICATE

TO BE COMPLETED BY AN AUTHORIZED MEDICAL DOCTOR

I certify that my patient _____ has a physical disability and is unable to move a solid waste collection cart to and from the collection point.

Signature: _____ Date: _____

Doctor's Name: _____

Address: _____

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.