CITY OF QUESNEL

Request for Garbage Set Out/Set Back

410 Kinchant St, Quesnel, BC V2J 7J5 | Phone: (250) 992-2111 | Fax: (250) 992-1512

Freedom of Information and Protection of Privacy act (FOIPPA): Personal information contained on this form is collected under the Freedom of Information and Protection of Privacy Act (FOIPPA) and will be used only for the purposes of responding to your request.

PART 1: APPLICANT INFORMATION

Date: _____ Full Name: _____

Property Address: _____ Postal Code: _____

Phone Number: _____ Email: _____

☐ New Application OR ☐ Renewal

Nature of Disability: _____ Number of Persons living in household: _____

PART 2: GARBAGE SERVICE CHANGES

I understand that collection crews will enter my private property to move a solid waste collection cart to the curb for collection and return it to the property. I as occupier of the above property hereby apply for this service and agree to the following conditions:

- The occupier of this property has a permanent physical disability that prevents him/her from moving the cart 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 your doctor sign the verification of disability section;
- The cart shall be freely accessible and not to 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 executing of this service.
- The City reserves the right to contact the applicant for a renewal to ensure that service is still required at any time.

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

_____ _____

Application Signature Date

MEDICAL DOCTOR ONLY - charges may apply (City is not responsible for these charges)

I certify that my patient:

has a permanent physical disability and is unable to move a solid waste collection cart to and from the collection point.

Doctor Signature: _____ Date:_____

Doctor Full Name (PRINT): _____ Phone: _____

Mailing Address: _____

OFFICE USE ONLY

Application approved: ☐ Yes ☐ No Date Received: _____

Date Approved/Rejected: _____

Signature of Director of Operations: _____