

**REQUEST FOR COURTESY SNOW BERM REMOVAL FROM DRIVEWAY**

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

**Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Physical Address:** \_\_\_\_\_

**Telephone:**           **Home:** \_\_\_\_\_           **Cell:** \_\_\_\_\_

**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

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**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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**FOR STAFF USE ONLY:**

**Date Received:** \_\_\_\_\_                   **By:** \_\_\_\_\_

**Application approved:**                   **Yes**                    **No**

**Route:** \_\_\_\_\_