DISTRICT OF HOPE
325 Wallace St., Hope, BC V0X 1L0
ph: 604.869.5671 fax: 604.869.2275 info@hope.ca

APPLICATION FOR SET OUT/SET BACK SERVICE

Please print clearly Date: _____

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

_____
(Street Number) (Street Name)

_____
(City) (Province) (Postal Code)

hereby apply for this service and acknowledge and agree to the following:

- I have limited or no physical mobility which restricts or prevents me from being able to bring my collection carts to the collection point;
- I do not have a person without a disability present to assist me with putting out and bringing in the collection carts;
- Carts will be freely accessible and not be placed inside closed buildings or gated areas;
- If a person without a disability becomes available prior to the expiry of an approval, I will notify the District and understand this service will end;
- The District is not responsible for any damage to my private property resulting from the executing of this service.

APPLICANT INFORMATION

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?

_____/_____/_____
(Month) (Day) (Year)

_____ _____ _____
Signature of Applicant Phone Number Date

REQUIREMENTS

Please submit this form with a completed Physician's Statement for Set Out/Setback Service.

OFFICE USE ONLY ☐ Your request is DENIED ☐ Your request is APPROVED

Approved by: _____ Date: _____

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PHYSICIAN'S STATEMENT FOR SET OUT/SET BACK SERVICE

Please print clearly Date: _____

Your patient is applying for a Set Out/Set Back Service under the District's Solid Waste Management Bylaw No. 1472, 2020. This form is provided to physicians in order to confirm that the person named below has limited or no physical mobility which restricts or prevents them from being able to bring their collection carts to the collection point at the patient's address below.

PATIENT INFORMATION

Patient Name: _____
(First Name) (Last Name)

Patient Address: _____
(Street Number) (Street Name)

_____
(City) (Province) (Postal Code)

Does the patient named above have limited or no physical mobility restricting or preventing them from being able to bring their collection carts to the collection point at the location specified above?

☐ Yes or ☐ No

Is the disability permanent? ☐ Yes or ☐ No

If the disability is not permanent, at what date would the Patient be sufficiently recovered?

_____/_____/_____
(Month) (Day) (Year)

Physician's Name: _____

☐ I certify that the information provided in this application is true and correct, based upon information given to me by the applicant.

_____ _____
Signature of Physician Date