

www.stcatharines.ca

PO Box 3012, 50 Church Street St. Catharines, ON L2R 7C2

Tel: 905.688.5600 | Fax: 905.646.6570

TTY: 905.688.4TTY (4889)

Snow Removal Application 2017 - 2018

The following is an application form for snow removal service for qualified **Seniors and Persons** with a **Disability**. Please read this application information carefully.

If you feel that you qualify for this service, ask your family doctor to complete the "Statement of Physician", on the application form, then complete the remainder of the application.

To qualify for snow removal service, you must:

- Have a disability, which (in the opinion of your physician) renders you incapable of carrying out snow removal on your own behalf, and;
- 2 Have no person living in the same dwelling unit who is physically capable of carrying out snow removal for you, and;
- Reside in a single family, semi-detached, or duplex dwelling unit **LOCATED IN THE CITY'S URBAN AREA**, and be the owner of such residence and;
- Agree to a waiver of claims against the City with respect to any property or other damage which might arise out of the service being provided.

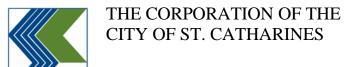
The completed application form should be **signed and witnessed**, as indicated, and returned to:

City of St. Catharines
Transportation and Environmental Services
Lake Street Service Centre
383 Lake Street
St. Catharines ON L2N 4H5

PLEASE NOTE:

THIS SERVICE CONSISTS OF SNOW REMOVAL FROM CITY SIDEWALKS FRONTING AND ABUTTING HOUSES OCCUPIED BY QUALIFIED SENIORS AND PERSONS WITH A DISABILITY. THIS SERVICE DOES NOT INCLUDE WINDROWS, DRIVEWAYS OR ANY WALKWAYS TO YOUR HOME.

Should you require additional information, please contact this office at 905-688-5601, extension 2160.



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TRANSPORTATION AND ENVIRONMENTAL SERVICES

APPLICATION FOR SNOW REMOVAL SERVICE

PROPERTY OWNER

Name:	
Address of Residence:	
Postal Code:	Telephone Number: 905-
STATEMENT OF PHYSICIAN:	
I,	
Name of Physici	an (Please Print)
HEREBY CERTIFY THAT:	
A disability renders the person(s), he carrying out snow removal at their pl	erein named as the applicant(s) / owner(s), incapable of ace of residence.
Signature of Physician:	
Office Address:	
Postal Code:	Telephone Number: 905-

APPLICANT'S / OWNER(S) STATEMENT OF QUALIFICATION AND WAIVER OF CLAIMS

- 1. No person lives with me who is capable of carrying out snow removal on my behalf.
- 2. I live in a single family, semi-detached or duplex dwelling unit and am the property owner of said residence.

WAIVER OF CLAIMS

I hereby acknowledge that I am requesting the Corporation of the City of St Catharines to remove snow from City-owned sidewalks fronting and abutting my residence.

I hereby waive any and all rights of claim against the Corporation of the City of St. Catharines and / or against officials, employees, agents, organizations and/or private citizens employed on a volunteer basis by or with the said City of St. Catharines, for property or other damages, which may arise from my being provided with the snow removal service that I am requesting.

Witness	Date	
Witness	Date	

RETURN APPLICATION TO:

City of St. Catharines
Transportation and Environmental Services
Lake Street Service Centre
383 Lake Street
St. Catharines ON L2N 4H5