Application #:	Approved:	Denied:	Date:	Initials:

For Internal Use Only

Driveway Snow Windrow Clearing
Medical Application

Medical/Health Practitioner Professional Information:

Name (Please print):	
License/Certification #	
Address:	
Telephone:	
Fax #:	
Email:	

	Licensed Physician		Licensed Chiropractor
	Licensed Physical Therapist		Certified Rehabilitation Specialist
	Registered Nurse (or RPN)		Certified Psychologist/Psychiatrist
	Registered Occupational Therapist		Licensed Optometrist/Ophthalmologist
	Other (Specify):		

Does this person have a physical disability or medical condition that impacts their ability to shovel their driveway during/after a snow event? Please Explain.

_____

_____

_____

Medical/Health Practitioner Signature: **Date:**

_____ _____

(dd/mm/yyyy)

Information collected on this form shall be used for the sole purpose in which it is intended/collected and shall remain confidential and subject to the Municipal Freedom of Information and Protection of Privacy Act.