**Township of South Glengarry**
6 Oak Street, P.O. Box 220, Lancaster, ON, K0C 1N0
T: (613) 347-1166 | F: (613) 347-3411
www.southglengarry.com

# Application for Authorized Waste Exemption (2027)

**First name of resident/person responsible**:_____

**Last name of resident/person responsible:** _____

Address:_____Municipality: _____Postal Code:_____

Telephone: _____Email:_____

Collection day (day of the week in which garbage is collected): _____

Please indicate the reason you are asking for a bag exemption:
◯ Agricultural Operation ◯ Medical Reasons ◯ Family over 6 ◯ Other

- **If for Medical Reasons, also complete the Waste Exemption for Medical Reasons (page 3.)**
- **If Agricultural Operation, provide Farm Business Registration Number:** _____
- **If other, please explain:** _____

_____

If your application is approved, you will be given special stickers to place on your extra bag(s). Stickers can be picked up **by appointment** from the Township of South Glengarry, 6 Oak Street, Lancaster, ON all between 8:30 am and 4:00 pm Monday through Friday, or mailed directly to your home.

**Number of extra bags per week requested: ◯ 1 ◯ 2**

**Please indicate if you would like to pick up your stickers, or have them mailed to you:**

◯ Pick up stickers (The Township will contact you when they are available for pick-up)

◯ Stickers mailed to your home (Please note that the Township shall not be held responsible for tags delayed or lost in the mail

**(additional $2.00 will be added to cover the costs of mailing)**

**Mailing Address**:_____

**Are you completing this application on behalf of the resident with the medical condition:**

◯ Yes
◯ No

If yes, state your relationship to the resident with the medical condition: _____

Delegate first name: _____ Delegate last name:_____

**Please complete and return this form by mail or email:**

Mail: Township of South Glengarry
ATTN: Infrastructure Coordinator
6 Oak Street, PO BOX 220
Lancaster, ON K0C 1N0
infrastructure@southglengarry.com
*Please mark all correspondence as confidential*

This **CONFIDENTIAL** application is for Township residents who may need to set out more than the limit of garbage bags/cans per week. Residents must currently receive curbside collection provided by the Township of South Glengarry

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**I acknowledge the following:**

- I will notify the Township if I move **or** no longer require a bag exemption.
- This application must be renewed annually (by December 31st) to ensure continued service.
- The Township of South Glengarry will not be responsible for any lost or stolen bag tags.
- I agree that any personal information provided here may be shared with your third-party contractor, HGC Management, to provide me with this service. I understand that this information will not be shared with any other party and will only be used to contact me with regards to my application.
- I agree to the terms above and hereby certify that the information provided is true and accurate.

◯ Please check if delegate is signing on behalf of resident with medical condition

Signature of resident or delegate: _____

Date: _____

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**INTERNAL USE ONLY**

Township of South Glengarry representative approval: _____

Date: _____

◯ This form has been approved and information sent to the contractor

*"This information is collected by The Corporation of Township of South Glengarry under the Municipal Freedom of Information and Protection of Privacy Act R.S.O. 1990, c. F.31, s. 39 (2) for the purposes of applying for a Waste Exemption."*

Address: _____ Municipality:_____Postal Code:_____

Telephone: _____ Email:_____

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# Waste Exemption for Medical Reasons (2027)

*Medical Exemption Only*

**This Section may be required every three (3) years from the year of initial application.**

Medical Professional's Name: _____

Medical Professional's Title: _____

Address: _____

Postal Code: _____ _____

Telephone: _____

**I certify that the above-named resident's medical condition results in the generation of additional garbage, and therefor will require exemption from the weekly bag limit.**

Medical Professional's signature: _____ _____

Date: _____ _____

Patient Name: _____

Patient Address: _____