City of Oakbrook Terrace

Driveway Snow Removal Program

Medical Disability Statement

DATE: _____ PATIENT NAME: _____

☐ I attest that this patient has a permanent disability that prevents him/her from shoveling snow.

☐ I attest that this patient has a temporary disability that prevents him/her from shoveling snow for this winter season.*

PHYSICIAN SIGNATURE:_____

PHYSICIAN NAME:_____

(Please Print)

Physician, please staple a prescription sheet from your office to this form.