

WHITTINGHAM HOMEOWNERS ASSOCIATION

2026-2027 PREFERENTIAL SNOW CLEARING

This application must be accompanied by a copy of the letter of authorization on physician's letterhead or prescription pad.

**** This application must be applied for annually through the Management Office ****

~ Please Print ~

Date of Application:

Name: _____

Home Phone #: _____

Address:

Reason for Applying: (must be medical necessity - not job related)

Medical Information:

Qualifying Treatments - chemo,
dialysis, hospice, and radiation.

Treatment Schedule (day(s) and time)

Name of Provider

Place of Treatment _____

Phone # of

Provider: _____

*This application **must** be accompanied by a copy of the letter of authorization on physician's letterhead or prescription pad.*

Date of Signature:

Resident Signature:



For Management Staff Use Only



Approved by: _____

Date: _____

Denied by: _____

Date: _____

Reason: _____