Physician Confirmation of
Fitness for Snow Removal Activities

After reviewing _____ medical history, it is
(Applicant Name)

my professional opinion that _____ should not or
(Applicant Name)

is unable to perform snow removal actions at this residence.

_____
Physician Signature

_____
Please Print Physician's Name

_____
Date

Physician's Contact Information:

_____
Practice Name

_____
Address

_____
City, State & Zip

_____
Phone #

City of St. Peters
Street Department
P.O. Box 9
St. Peters, MO 63376