CITY OF VANCOUVER

Vacancy Tax (Empty Homes Tax) Medical Treatment Certification

Financial Services
Revenue Services

Freedom of Information and Protection of Privacy Act (FIPPA) – the personal information on this form is collected for the purposes of administering the Vacancy Tax (Empty Homes Tax) under the authority of section 26(a) and 26(c) of FIPPA and section 620 of the Vancouver Charter. Questions about the collection or use of this information can be directed to the City of Vancouver's Access to Information and Privacy Office, privacy@vancouver.ca

PART 1 – PROPERTY OWNER INFORMATION

FULL LEGAL NAME OF PROPERTY OWNER

PROPERTY ADDRESS (include unit or house number, street name, and city)	POSTAL CODE
OWNER'S MAILING ADDRESS (include unit or house number, street name, and city)	POSTAL CODE

FOLIO NUMBER	TELEPHONE NUMBER	EMAIL ADDRESS (optional)

Check (✓) to confirm the medical exemption you claimed. A medical practitioner must complete the certification in Part 3.

☐ **Secondary residence close to medical treatment facility (section 3.11)** – applies when a secondary residence is periodically occupied by an owner (or their spouse or dependent) for participation in a course of treatment:
(a) that, in the opinion of a medical practitioner, is required for the health of the individual; and
(b) that is impractical for the individual to obtain in reasonably close proximity to the individual's principal residence;

Property Owner Certification - I certify that all information provided in Part 1 of this form is true and correct to the best of my knowledge and belief. I understand all information is subject to audit and verification.

SIGNATURE OF OWNER ✘	DATE SIGNED (YYYY/MM/DD)

PART 2 – PATIENT RECEIVING MEDICAL TREATMENT

FULL NAME OF PATIENT (complete even if owner named above)	PATIENT'S RELATIONSHIP TO OWNER (if owner, enter owner)	MEDICAL TREATMENT FACILITY NAME

MEDICAL TREATMENT FACILITY ADDRESS (include unit or house number, street name, and city)	POSTAL CODE

Patient Certification - I certify that all information provided in Part 2 of this form is true and correct to the best of my knowledge and belief, and I authorize the owner to submit this completed form to the City of Vancouver for purposes of administering the Vacancy Tax. I understand all information is subject to audit and verification. (Note: an adult guardian must sign on behalf of a child under the age of 19.)

SIGNATURE OF PATIENT ✘	DATE SIGNED (YYYY/MM/DD)

PART 3 – MEDICAL PRACTITIONER'S CERTIFICATION – TO BE COMPLETED BY A MEDICAL PRACTITIONER ONLY

Once completed, return the form to the individual with the medical condition

FULL NAME OF MEDICAL PRACTITIONER	CERTIFICATION/FELLOWSHIP	TELEPHONE NUMBER

MAILING ADDRESS	POSTAL CODE

I certify that in my professional opinion, the patient noted in Part 2 is participating in a course of treatment that is required for the health of the individual.

SIGNATURE OF MEDICAL PRACTITIONER ✘	DATE SIGNED (YYYY/MM/DD)

City of Vancouver, Finance, Risk and Supply Chain Management
Financial Services, Revenue Services
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