Finance Department
Accommodation Tax By-Law No. 4448
Application for Accommodation Tax Refund
Form AT04-2011

APPLICANT FOR REFUND OF ACCOMMODATION TAX – INSTRUCTIONS:

- Complete this form to apply for a general refund of the Accommodation Tax
- A refund can only be claimed within one year of payment or remittance of the tax; for a tour operator the transition period ends on August 1, 2012
- A claim will not be processed if the required documents / information are not supplied
- Please complete Parts A, B, C and D type or print clearly and submit all required documents
- Make a copy of this Application for Refund and any attachments for your records
- If you require additional information call the Finance Department: 627-1100

PART A

CLAIMANT INFORMATION

NAME OF CLAIMANIT – legal name of individual, corporation or society

MAILING ADDRESS | HOME PHONE NO. | WORK PHONE NO.

CITY | PROVINCE | POSTAL CODE | FAX NO.

PART B

REFUND INFORMATION

I am applying for a refund in the amount of : $

Note: A refund can only be paid to the person who actually paid the tax. No refund will be paid to third parties acting on behalf of the claimant. Indicate the amount of accommodation tax you are applying for. Do not include Federal Goods and Services Tax (GST) or the Provincial Retail Sales Tax (PST) on this application.

Indicate the reason for claiming this refund. See next page for required documents to support your claim

If more space is required please attach a separate sheet

Check (√) the box that applies:	Name/Address of Establishment	Date(s) of Stay	Accommodation Tax Paid
☐ Refund to accommodation operator			
☐ Refund to purchaser for medical treatment			
☐ Refund to purchaser for other reasons			
☐ Refund to tour operator (transition period)			

PART C

MEDICAL TREATMENT INFORMATION: To be completed by Medical Facility or Physician. In lieu of completing Part C, a letter from the Medical Facility or Physician will be accepted (see next page).

Name of Medical Facility / Physician: _____

Name of Patient receiving treatment/testing: _____

City / Town of Patient (principle residence): _____

Date(s) of treatment / testing: _____ **MM/DD/YYYY** **TO** _____ **MM/DD/YYYY**

Signature of Facility Representative / Physician: _____

PART D

CLAIMANT DECLARATION

I declare that all information provided on this form and on the attached documents is true and correct to the best of my knowledge and belief. I acknowledge that any false information may result in prosecution, a fine of up to $50,000 and or imprisonment for up to six months.

NAME – Please type or print | Organization Position/Title | Signature

_____

Date: _____
MM/DD/YYYY