



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

P A R T	CLAIMANT INFORMATION			
	NAME OF CLAIMANT – legal name of individual, corporation or society			
	MAILING ADDRESS	HOME PHONE NO.	WORK PHONE NO.	
		()	()	
A	CITY	PROVINCE	POSTAL CODE	FAX NO.
				()

P A R T	REFUND INFORMATION		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.	
	I am applying for a refund in the amount of : \$			
	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			
B	Check (✓) the box that applies:	Name/Address of Establishment	Date(s) of Stay	Accommodation Tax Paid
	<input type="checkbox"/> Refund to accommodation operator	_____	_____	_____
	<input type="checkbox"/> Refund to purchaser for medical treatment	_____	_____	_____
	<input type="checkbox"/> Refund to purchaser for other reasons	_____	_____	_____
	<input type="checkbox"/> Refund to tour operator (transition period)	_____	_____	_____

P A R T 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:	_____	TO	_____
		MM/DD/YYYY		MM/DD/YYYY
	Signature of Facility Representative / Physician:	_____		

P A R T 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		

