

Comment on the Queenstown Arterials Project Fast-track Application and Notice of Requirement

All sections of this form with an asterisk (*) are mandatory.

1. Contact Details

Please ensure that you have authority to comment on the application on behalf of those named on this form.

Organisation name (if relevant)	SKYDIVE QUEENSTOWN LTD .		
*First name	CLARK		
*Last name	SCOTT .		
Postal address	P.O.Box 554 QUEENSTOWN .		
*Home phone / Mobile phone	021 592 030	*Work phone	
*Email (a valid email address enables us to communicate efficiently with you)	c.scott@experienceco.co.nz .		

2. *We will email you draft conditions of consent for your comment about this application

<input checked="" type="checkbox"/> I can receive emails and my email address is correct	<input type="checkbox"/> I cannot receive emails and my postal address is correct
--	---

3. Please provide your comments on the Queenstown Arterials Project Application

If you need more space, please attach additional pages. Please include your name, page numbers and [insert project name] Application on the additional pages

SEE FOLLOWING .

We look forward to the completion of the downtown arterial route which we know will enhance the Queenstown experience for all.

However please be mindful of the following critical requirements for ours and other businesses in the CBD,

- The requirement/necessity to maintain access for different classes of vehicles ie customer service and convenience for our tourists.
- Maintaining existing /sufficient loading zones for said vehicles to pick up and drop off.

Kind regards

A handwritten signature in blue ink, appearing to be 'R. D.', written in a cursive style.

Skydive Queenstown Ltd