

MEDICAL EMERGENCY CERTIFICATION

Date: _____

CERTIFYING PHYSICIAN (Please complete by typing or printing requested information)

I CERTIFY THAT THE AFFLICTED PERSON IS SERIOUSLY ILL OR IS AFFLICTED WITH A MEDICAL CONDITION WHICH WILL BE AGGRAVATED BY THE TERMINATION OF WATER SERVICE.

1. NAME AND ADDRESS OF CUSTOMER:

Name Service Address

2. NAME AND ADDRESS OF THE AFFLICTED PERSON AND THEIR RELATION TO THE CUSTOMER:

Afflicted Person Relationship

3. NATURE AND ANTICIPATED LENGTH OF AFFLICTION:

Nature

Date Became Afflicted with Illness Anticipated Length

_____ gallons/per week
If water is needed for operation of equipment; what is the estimated quantity needed per week

Physician's Signature Date

Physician's Office Address

Physician's Telephone Number

The maximum length of the certification is 30 days from date received in office. Certification may be renewed for an additional 30 days if needed. The Ratepayer is still responsible to make payments on his/her bill. A payment agreement must be executed prior to approval of this form