# PHYSICIAN'S CERTIFICATION OF ILLNESS FORM FOR CUSTOMERS

<table>
<tr><th colspan="5">CUSTOMER INFORMATION</th></tr>
<tr><td colspan="2">Account Number:</td><td colspan="3">Date:</td></tr>
<tr><td colspan="5">Customer Name:</td></tr>
<tr><td colspan="2">Street Address:</td><td>Bldg#:</td><td colspan="2">Apt#:</td></tr>
<tr><td>City:</td><td>State:</td><td>Zip:</td><td colspan="2">Telephone:</td></tr>
<tr><td colspan="5">Patient's Name, residing at above address:</td></tr>
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<tr><th>CUSTOMER AUTHORIZATION</th></tr>
<tr><td>I authorize Hazardville Water Company to certify with my physician that my medical condition is a serious illness or life threatening situation.</td></tr>
<tr><td>Patient, Guardian or Conservator's Name (Print):</td></tr>
<tr><td>Patient, Guardian or Conservator's Signature:</td></tr>
<tr><td>The utility has the right to contest the validity of any physician's certification before the Department of Public Utility Control. See Conn. Agencies Regs. § 16-3-100(e)(1) and (e)(5).</td></tr>
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<tr><th colspan="2">TO BE COMPLETED BY THE PHYSICIAN</th></tr>
<tr><td colspan="2">The utility will provide protection from a service shutoff if a registered physician certifies the patient listed below is seriously ill or has a life threatening situation. See Conn. Agencies Regs. § 16-3-100.</td></tr>
<tr><td colspan="2">Please review the illness classifications listed below and select the one that best describes your patient's condition.</td></tr>
<tr><td>☐ <u>Serious Illness:</u></td><td>My patient is seriously ill. However, not having water service <u>will not</u> endanger the life of my patient.</td></tr>
<tr><td>☐ <u>Life Threatening:</u></td><td>My patient has a medical condition and not having water service <u>will</u> endanger the life of my patient. The household is protected from a service shut-off for nonpayment year round.</td></tr>
<tr><td colspan="2">Please select the length of the serious or life threatening situation.<br>☐ 1 month or less ☐ 1-3 months ☐ 3-6 months ☐ 6-9 months ☐ 9-12 months ☐ 1 year or more<br>This form must be completed every 15 days if no length of illness is specified.</td></tr>
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<tr><th colspan="2">PHYSICIAN CERTIFICATION</th></tr>
<tr><td colspan="2">I certify, under penalty of law pursuant to Conn. Gen. Stat. Sec. 20-13c or as otherwise provided by law, that the information provided regarding my patient is true and accurate to the best of my knowledge.</td></tr>
<tr><td>*Patient's Name:</td><td></td></tr>
<tr><td>*Patient's Address:</td><td></td></tr>
<tr><td>*Physician's Name:</td><td></td></tr>
<tr><td>*Physician's Address:</td><td></td></tr>
<tr><td>*Physician's Telephone Number:</td><td>*Fax Number:</td></tr>
<tr><td>*Physician's Signature:</td><td>*Provider State License #:</td></tr>
<tr><td colspan="2">*Information required to process certification form.</td></tr>
<tr><td colspan="2">Please return the completed form by fax or mail within seven (7) days of receipt.</td></tr>
<tr><td>Hazardville Water Company<br>PO Box 1248<br>Enfield, CT 06083</td><td>Telephone: 860 749-0779<br>Fax: No. 860 749-5381</td></tr>
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