CITY OF UNION
SPECIAL NEEDS CUSTOMER MEDICAL CERTIFICATION FORM
(Please Type or Print all Information)

Customer Information to be completed by Customer:

Name _____ Account Number _____

Social Security Number _____

Work Phone _____ Home Phone _____ Cell Phone _____

Account Address _____

Patient's Name _____

Please read the following and initial each one:

_____ I certify that the patient named above is a member of my household residing at the above address.

_____ I understand that this Certificate will expire between November 1 and November 30, according to your billing cycle, and must be resubmitted annually by this date to continue participating in the Special Needs Customer Program.

_____ I further understand that this in no way releases me from my obligations to pay my monthly bill in accordance with the City's standard payment terms.

Customer's Signature _____ Date_____

Certificates are not issued for water service that is subject to disconnection.

Medical Information below to be completed by a SC Licensed Healthcare Provider
I certify that I have examined the patient named above and, in my professional opinion as a medical doctor, physician's assistant, nurse practitioner or advanced-practice registered nurse licensed by the State of South Carolina, I certify it would be especially dangerous to my patient's health if the **electricity** and/or **natural gas** is disconnected for nonpayment of bills for the reason circled below. (The City of Union will attempt to notify these customers of a planned outage whenever reasonably possible.)

Nebulizer for Asthma, Lungs	Feeding (Pump) Machine	Oxygen Machine
Heart Monitor	Infant Apnea Monitor	Ventilator/Respirator
Home Dialysis treatment	Refrigeration for Insulin	

(CPAP machines for adult sleep apnea **do not** qualify.)

FOR OFFICE USE ONLY:

1. INT _____ DATE _____

2. INT _____ DATE _____

A detailed explanation for reasons not mentioned above must be submitted for review.

Health Care Provider Name _____ Office Phone _____

SC Medical License Number _____
Circle one that applies: Medical Doctor, Physician's Assistant, Nurse Practitioner, Advanced-Practice Registered Nurse

Office Address _____

Health Care Provider Signature _____ Date _____

This form must be faxed (864-429-1780) or e-mailed (utilities@cityofunion.org) from the office of the SC licensed healthcare provider to the City of Union