



# AQUARION

Water Company

*Stewards of the Environment*

## PHYSICIAN'S CERTIFICATION OF ILLNESS FORM FOR AQUARION CUSTOMERS

CUSTOMER INFORMATION			
Aquarion Account Number:		Date:	
Customer Name:			
Street Address:		Bldg#:	Apt#:
City:	State:	Zip:	Telephone:
<b>Patient's Name, residing at above address:</b>			

CUSTOMER AUTHORIZATION
I authorize Aquarion Water Company to certify with my physician that my medical condition is a serious illness or life threatening situation.
Patient, Guardian or Conservator's Name (Print):
Patient, Guardian or Conservator's Signature:

**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).**

TO BE COMPLETED BY THE PHYSICIAN
The utility will provide protection from a service shutoff if a registered physician certifies the patient listed below is <b>seriously ill</b> or has a <b>life threatening situation</b> . See Conn. Agencies Regs. § 16-3-100.
Please review the illness classifications listed below and select the one that best describes your patient's condition.
<input type="checkbox"/> <b><u>Serious Illness:</u></b> My patient is seriously ill. However, not having water service <b><u>will not</u></b> endanger the life of my patient.
<input type="checkbox"/> <b><u>Life Threatening:</u></b> My patient has a medical condition and not having water service <b><u>will</u></b> endanger the life of my patient. The household is protected from a service shut-off for nonpayment year round.
<p align="center"><b>Please select the length of the serious or life threatening situation.</b></p> <input type="checkbox"/> 1 month or less <input type="checkbox"/> 1-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-9 months <input type="checkbox"/> 9-12 months <input type="checkbox"/> 1 year or more <b>This form must be completed every 15 days if no length of illness is specified.</b>

PHYSICIAN CERTIFICATION	
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.	
*Patient's Name:	
*Patient's Address:	
*Physician's Name:	
*Physician's Address:	
*Physician's Telephone Number:	*Fax Number:
*Physician's Signature:	*Provider State License #:
<b>*Information required to process certification form.</b>	

Please return the completed form by fax or mail to Aquarion Water Company within seven (7) days of receipt.	
Aquarion Water Company 200 Monroe Turnpike Monroe, CT 06468	Telephone: 1-203-445-7310 1-800-732-9678 Fax: 1-203-445-7308