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:
Patient's Name, residing at above address:			

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).Please note: You will be required to make an equitable arrangement to pay your past due bills and to pay on a current basis all future bills while the illness continues.

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 **seriously ill** or has a **life threatening situation.** 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.	
☐**Serious Illness:**	My patient is seriously ill. However, not having water service ***will not*** endanger the life of my patient.
☐**Life Threatening:**	My patient has a medical condition and not having water service ***will*** endanger the life of my patient. The household is protected from a service shut-off for nonpayment year round.

Please select the length of the serious or life threatening situation.

☐1 month or less ☐1-3 months ☐ 3-6 months ☐6-9 months ☐9-12 months ☐ 1 year or more

This form must be completed every 15 days if no length of illness is specified.

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 #:
***Information required to process certification form.**	

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: Fax•	1-203-445-7310 1-800-732-9678 1-203-445-7308