

**Commissioners of Public Works (CPW)
of the City of Greenwood, S.C.**

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 in June 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 CPW'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. (CPW 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.)

Please refer to other side for additional information.

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 from the office of the SC licensed healthcare provider to CPW. See contact information below:

Fax # 864-942-8114