

**VILLAGE OF WELLINGTON UTILITIES
APPLICATION FOR MEDICAL ALERT CUSTOMER STATUS**

I certify that I have, or someone in my household has, a medical need for water. This condition is certified by a licensed physician practicing in the State of Florida. I understand that it is my responsibility to pay any outstanding utility bills to The Village of Wellington Utilities, and that failure to do so will result in termination of utility services. I also understand that water served to my residence is subject to unscheduled interruptions and that it is my responsibility to report them to the Village of Wellington Utilities.

Utilities Account #

Date Signed

Service Address

City

State

Zip

Print/Type Name of Person with
Medical need.

Signature of Person, Parent or Guardian of
Person with Medical need.

PHYSICIAN'S STATEMENT OF CERTIFICATION

Note to Physician: Please complete all spaces provided

This is to certify that _____ has a medical need for water and could suffer life threatening conditions if without water for more than _____ hours. I recommend that water not be intentionally interrupted without prior notification. This certification is effective _____ through _____.

Date

Date

Physician's Name

Physician's Address

Physician's Telephone Number

Physician's License or Certification Number

Physician's Signature

Note: This special service is subject to expiration on or after the date provided by the licensed physician.