Medical Documentation Request Form

(Application and Re-Certification)

PLEASE DO NOT PROVIDE ANY PERSONAL OR MEDICAL CONDITION INFORMATION

Name on water account: _____ Acct No.: _____

Service Address: _____ City: _____ Zip: _____

Phone Number: (____) _____ ☐ Home ☐ Cell ☐ Work

Name of person with medical requirements: _____

This form is required to verify that the person listed above has a medical condition that would require additional water to be used in the home. This form MUST be signed by a certified Doctor. An additional allocation will be provided only if your minimum winter month's use is exceeding your Indoor Allocation.

Additional water is required for (please check all that apply):

☐ Baths: How many baths per week? _____

☐ Showers: How many showers per week? _____

☐ Laundry: How many loads of laundry per week? _____

☐ Toilet Flushes: How many toilet flushes per week? _____

☐ Other: Please explain: _____

Doctor's Name: _____ Phone No. _____

Office Address: _____

MD/DO California State License or Military License: _____

Signature of Doctor (MD/DO only): _____

☐ Temporary - Expiration Date: _____

☐ Permanent – Recertification is required every 2 years Date: _____

MAIL: **EMWD**
Attn: Conservation Dept.
P.O. Box 8300, Perris, CA 92572-8300

EMAIL: conservation@emwd.org
FAX: **(951) 928-6120**

FOR EMWD USE ONLY

Tracking # _____ Account # _____ Date Logged: _____

Form #: Medical Variance Request
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