TOWN OF WATERTOWN
WATER AND SEWER AUTHORITY

PHYSICIAN'S CERTIFICATION OF SERIOUS ILLNESS

TO BE COMPLETED BY PHYSICIAN or APRN

The Town of Watertown WSA customer referenced below is seeking to prevent termination of his or her water service due to the fact that the customer, or someone within the household, is suffering from a serious illness or life threatening condition. In accordance with Conn. Gen. Stat. § I 6-262d, the WSA will not terminate service to the customer's property, provided that a physician certifies in writing that the customer, or someone within the household, is suffering from a serious illness or a life threatening condition that would be detrimentally affected by the loss of water service. **After certification of a serious illness or life threatening condition, the customer is nonetheless still required to enter into a reasonable installment plan and pay all current charges for water use.**

Patients Name: _____ Phone #:_____

Property Address: _____ Account #:_____

The above referenced patient is considered to be suffering from (check one):

- □ No serious illness or life threatening condition.
- □ A serious illness for which water is vital to the patients condition for reasons other than taking medication.
- □ A life threatening condition that would endanger the life of the customer or a member of the customer's household if water service were terminated.

Description of illness and requirement for water:

_____

_____

_____

Please indicate the duration of any serious illness or life threatening condition identified above. Any duration over l year will require a new certification form to be completed after 1 year.

□ 1 month or less	□ 1-3 months	□ 4-6 months	□ 6-9 months	□ 9-12 months

PHYSICIAN CERTIFICATION

I certify, under penalty of law pursuant to C.G.S. § 20-13c or as otherwise provided by law, that the information contained within this certification regarding my patient is true and accurate to the best of my knowledge.

Physician/APRN's Name:_____ Phone #: _____

Physician/APRN's Address: _____ Fax #: _____

Physician/APRN's Signature:_____ State License #: _____

Date: _____

Please complete and return this form within seven days of receipt to:
Town of Watertown WSA 747 French St. Oakville, CT 06779
Telephone: (860) 945-5299 Fax: (860) 945-5298