## Aqua Ohio 30-Day Medical Certification

**Instructions:**

The following is to be completed by a licensed medical professional and only after you, or someone in your office, has examined the individual whose name appears as the patient on the form below. This form applies only in situations where, in your professional opinion, termination of water utility service would be especially dangerous to the health of that individual. If, in your professional opinion an especially dangerous situation does not exist, please do not sign this form.

If you have any questions regarding this form, please contact: Aqua 762 W. Lancaster Avenue Collections Department Bryn Mawr PA or phone: 877-987-2782. You may fax the completed form to us at 866-780-8301.

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**I certify that, to the best of my knowledge, the information provided below is true.**

The following medical information must be certified by one of the following. Please indicate if you are a:

□ licensed physician □ physician assistant
□ clinical nurse specialist □ certified nurse practitioner
□ certified nurse-midwife □ local board of health physician

**Please complete the following. Please print.**
I certify that my patient has been examined by me and I have determined the following to be true:

Name of patient: _____
Patient's permanent residence: (street address)_____
(city, state, zip code)_____

Check the box of the applicable condition:

☐ **This patient suffers from a hazardous medical condition and termination of water utility service would be especially dangerous or life-threatening.**

☐ **This patient uses medical or life-supporting equipment and termination of water utility service would make operation of that equipment impossible or impractical.**

I certify that I advised my patient that disclosure of the requested information may be subject to redisclosure by the recipient and no longer be protected by the HIPAA rules and regulations.

**Authorized Signature**_____
**Date** _____

**(Please Print)**
Name of Licensed Medical Professional_____
Business Address _____
Business Telephone_____
Current State License or Certificate Number: _____

**All sections must be fully completed in order to process the medical certification request.**