GREER CPW
FOCUSING OUR ENERGY ON YOU.

PO Box 216
Greer, SC 29652
Phone: 864 848-5500
Fax: 864-968-2161
www.greercpw.com

SPECIAL NEEDS CUSTOMER MEDICAL CERTIFICATION FORM

Customer Information to be completed by Customer:

Name on Account _____ CPW Account # _____

Address: _____

Work Phone _____ Home Phone _____ Cell Phone _____

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 one year from November 30th 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 obligation 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 electric and/or natural gas is disconnected for nonpayment of bills for the reason circled below. (Greer 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	Alzheimer/Dementia

(CPAP machine for adult sleep apnea does not qualify)

A detailed explanation for reasons not mentioned above must be submitted for review.

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Healthcare Provider Name_____ Office Phone _____

SC Medical License Number _____

Circle one that applies: Medical Doctor, Physician's Assistance, Nurse Practitioner, Advanced-Practice Registered Nurse

Office Address _____

Healthcare Provider Signature _____ Date _____

This form must be faxed to Greer Commission of Public Works at 864-968-2161 or e-mailed to ic.customer@greercpw.com from the office of a SC licensed healthcare provider.