PO Box 216
Greer, SC 29652
Phone: 864-848-5500
Fax: 864-968-2162
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 medial 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 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
(CPAP machine for adult sleep apnea do not qualify)

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

Healthcare Provide 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 864-968-2162 or e-mailed to **csr@greercpw.com** from the office of the SC license healthcare providers to Greer Commission of Public Works