GREER CPW SPECIAL NEEDS CUSTOMER MEDICAL CERTIFICATION FORM
(Please Type or Print all Information)

Customer Information to be completed by Customer:

Name_____ Account Number _____

Social Security Number (last four digits) _____ Phone Number _____

Email Address _____

Account Address_____

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 signed date 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 obligations to pay my monthly bill in accordance with Greer CPW's standard payment terms.

Customer's Signature_____ Date_____

* Customer assumes the responsibility to notify Greer CPW of any changes to the contact information listed on this form.

*Special Needs Customers are encouraged to submit a Third Party Notification Form

Certifications 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 South Carolina, I certify it would be especially dangerous to my patient's health if the electricity or 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's disease or dementia

Other:_____
(CPAP machines for adult sleep apnea **do not** qualify)

Health Care Provider Name _____ Office Phone _____

Medical License Number _____

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

Office Address _____

Health Care Provider Signature _____ Date _____

By signing this Special Needs Customer Medical Certification Form, the Health Care Provider hereby promises to Greer CPW that such Health Care Provider has complied with all federal and state laws concerning health care privacy including HIPPA and that the release of this form under the conditions set forth herein does not violate such laws. In addition, by signing the above form, the Customer / Patient hereby consent to the release of all information set forth in the form from the Health Care Provider to Greer CPW, its employees, agents and contractors.

This form must be faxed to 864-968-2162 or e-mailed to csr@greercpw.com directly from the office of the SC licensed healthcare provider.