Medical Documentation Request Form
(Application and Re-Certification)

PLEASE DO NOT PROVIDE ANY PERSONAL OR MEDICAL CONDITION INFORMATION

Name on water account: _______________________________________ Acct No.: _________________

Service Address: ____________________________ City: ___________________ Zip: _______________

Phone Number: (____) _______________________

Name of person with medical requirements: ________________________________________________

This form is required to verify that the person listed above has a medical condition that would require additional water to be used in the home. This form MUST be signed by a certified Doctor. An additional allocation will be provided only if your minimum winter month’s use is exceeding your Indoor Allocation.

Additional water is required for (please check all that apply):

☐ Baths: How many baths per week? __________

☐ Showers: How many showers per week? __________

☐ Laundry: How many loads of laundry per week? __________

☐ Toilet Flushes: How many toilet flushes per week? __________

☐ Other: Please explain: ______________________________________________________

Doctor’s Name: ____________________________________ Phone No. ________________

Office Address: __________________________________________________________________

MD/DO California State License or Military License: _______________________________________

Signature of Doctor (MD/DO only): ____________________________________________________

☐ Temporary - Expiration Date: __________

☐ Permanent – Recertification is required every 2 years Date: ______________

MAIL: \ EMWD
Attn: Conservation Dept.
P.O. Box 8300, Perris, CA 92572-8300

EMAIL: conservation@emwd.org
FAX: (951) 928-6120

FOR EMWD USE ONLY
Tracking # ___________________ Account # ___________________ Date Logged: _____________

Form #: Medical Variance Request
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