CITY OF MILPITAS

WATER FORM 998-A

CERTIFICATION OF PRIMARY CARE PROVIDER

ACCOUNT HOLDER INFORMATION The section below to be filled out by the Residential Account Holder	
ACCOUNT NUMBER	**ACCOUNT HOLDER NAME**
ACCOUNT HOLDER PHONE NUMBER	**ACCOUNT HOLDER EMAIL**
SERVICE ADDRESS	**PERSON RECEIVING PRIMARY CARE**
DATE OF BILL REQUESTING PAYMENT ARRANGEMENT	**AMOUNT OF BILL REQUESTING PAYMENT ARRANGEMENT**

ACCOUNT HOLDER CERTIFICATION:

By signing below, I, the account holder, am certifying under perjury that the above-names person receiving primary care resides at the services address indicated above.

_____ _____ _____

Account Holder Signature | Print Name | Date

PRIMARY CARE PROVIDER CERTIFICATION The section below to be filled out by the Primary Care Provider	
PATIENT NAME	**NAME OF PRIMARY CARE PROVIDER**
CLINIC NAME	**CLINIC ADDRESS**
CLINIC PHONE NUMBER	**NATIONAL PROVIDER IDENTIFIER**

PRIMARY CARE PROVIDER CERTIFICATION:

By signing below, I, the primary care provider, am certifying under perjury that the above-named person and that discontinuation of water service to this person would pose a serious threat to his or her healthy and safety.

_____ _____ _____

Primary Care Provider Signature | Print Name | Date

FOR OFFICE USE ONLY		
DATE	**RECEIVED BY**	**COMPLETE**