



CRITICAL CUSTOMER ANNUAL CERTIFICATION

DESIGNATION IS VALID FOR
ONE YEAR AND MUST BE
RECERTIFIED ANNUALLY

SECTION I TO BE COMPLETED BY THE CUSTOMER OR THEIR REPRESENTATIVE

LAST NAME: _____ FIRST: _____ MI: _____

FACILITY NAME:

CUSTOMER
ADDRESS

CUSTOMER
ACCOUNT NUMBER:

CITY, STATE, ZIP

CUSTOMER
NUMBER:

NAME OF PERSON
COMPLETING FORM

HOME
PHONE NUMBER:

RELATIONSHIP TO
CUSTOMER

DAYTIME
PHONE NUMBER:

I CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS CORRECT AND THAT THE INDIVIDUAL OR FACILITY NAMED ABOVE RESIDES AT THE SERVICE ADDRESS SHOWN. I ALSO UNDERSTAND THAT ALTHOUGH BJWSA CANNOT GUARANTEE THAT THERE WILL BE NO DISRUPTION OF SERVICES, BJWSA IS COMMITTED TO MINIMIZING THE IMPACT ON THOSE WHO ARE DESIGNATED AS CRITICAL CUSTOMERS.

SIGNATURE

DATE

SECTION II TO BE COMPLETED BY A LICENSED PHYSICIAN

I CERTIFY THAT I AM A LICENSED PHYSICIAN AND:

- IN MY PROFESSIONAL OPINION THE ABOVE NAMED INDIVIDUAL OR FACILITY POSSESSES A MEDICAL OR OPERATIONAL NEED THAT WOULD BE AGGRAVATED BY THE ABSENCE OF WATER.

- THE CONDITION IS PERMANENT OR TEMPORARY IN NATURE.

PRINTED NAME

OFFICE PHONE NUMBER

SIGNATURE

DATE

THE DESIGNATION OF A CRITICAL CUSTOMER BY BJWSA DOES NOT RELIEVE ANY CUSTOMER THE RESPONSIBILITY TO MAKE PAYMENT FOR SERVICES RENDERED.