

ACCEPTANCE INTO THE MEDICAL CUSTOMER PROGRAM DOES NOT GUARANTEE CONTINUOUS WATER SERVICE. CUSTOMERS WHOSE SERVICE IS CRITICAL FOR LIFE SUPPORT SHOULD MAKE PRIOR EMERGENCY ARRANGEMENTS TO ACCOMMODATE THE MEDICAL PATIENT IN CASE OF WATER INTERRUPTIONS.

TO BE FILLED IN BY CUSTOMER

CUSTOMER NAME _____ ACCOUNT NUMBER _____

STREET ADDRESS _____ CITY & STATE _____ ZIP CODE _____ HOME /WORK _____

PATIENT'S NAME _____ BIRTHDATE _____ PHYSICIAN'S NAME & PHONE _____

Authorization: I hereby authorize release of any medical information that is pertinent to my qualifying as a medical customer with Kansas City Water Services. By signing below applicant acknowledges the accuracy and truth of the information provided.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN _____ DATE _____

TO BE FILLED IN BY PHYSICIAN

PLEASE RESPOND TO THE FOLLOWING ISSUES: Is the patient bedfast? YES ___ NO ___

Nature of Ailment _____

What type of water-powered medical equipment is required? _____

Is continuous use of the water equipment necessary? YES ___ NO ___ If yes, Why? _____

Is there back-up equipment available in case of water interruption? YES ___ NO ___

What is the frequency of use for this equipment? _____

Is the patient's condition temporary? YES ___ NO ___ If yes, estimated time when condition would warrant removal from medical customer list. _____

Additional Comments: _____

PHYSICIAN'S SIGNATURE _____ OFFICE ADDRESS _____

PHYSICIAN'S NAME (Please Print) _____ DATE _____ CITY, STATE, ZIP CODE _____


For Kansas City Water Services Use Only	APPROVED _____	DENIED _____
BY _____	DATE _____	
COMMENT: _____		

Questions?

Please contact Customer Service via:
Telephone: 816-513-1313
Fax: 816-513-0116

MAIL: KC Water
 Attn: Customer Service
 4800 E. 63rd St.
 Kansas City, MO 64130

E-mail: water.customerservice@kcmo.org

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