City of Kingman

Physician Certification

Please have your physician complete this form and attach a page/sheet of his/her office letterhead or official prescription pad to this form.

1. I,_____(Doctor's name-PLEASE PRINT OR TYPE), am a licensed physician.

2._____
(patient's name, address, phone number is currently under my care.

3. This patient requires the use of _____
(medical equipment using tap water) that:

   - ○ Is necessary for life support (e.g. it would be especially dangerous to the patient's health if equipment was not available.
   - ○ Protection Dates/Temperature-based yes/no Temperature____F and below or___F and above.
   - ○ Is not necessary for life support.

4. The medical equipment used at the address above is dependent on tap water for operation.

_____
(Physician Signature) (Phone Number)

_____
(Physician Address)

_____
(City) (Zip Code)

_____
(Date)

The patient will be required to recertify with his/her physician every two years.

Please return this form to: City of Kingman-Water Department
310 N. Fourth Street
Kingman, AZ 86401
Phone; 928-753-6651
Fax: 928-753-6867