



*City of Anderson
Utility Office*

**P.O. Box 2100
Anderson, Indiana 46018
(765) 648-6187 Fax (765) 648-5929
www.cityofanderson.com**

**Water Department
Medical Letter**

CUSTOMER INFORMATION

(Please print or type)

Date: _____ Meter # _____

Customer Name: Mr. Mrs. Ms. _____

Service Location: _____

Phone #: _____ Acct #: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip Code: _____

THIRD PARTY INFORMATION

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

*I understand if I move from the Service Location above I must submit a new medical form for my new location. **This form will not transfer to a new address***

Signature of Occupant: _____

LIFE SUPPORT INFORMATION

(To be completed by Physician)

Type of equipment: _____

Doctor's Name (Please print): _____

Phone #: _____ Address: _____

City: _____ State: _____ Zip: _____

Doctor's Signature: _____

Comments: