



An Essential Utilities Company

**MEDICAL CERTIFICATE FORM**

**To Be Completed By The Physician, Nurse Practitioner, or Physician's Assistant**

**CUSTOMER / PATIENT INFORMATION**

Name of the customer or applicant in whose name the utility account is or will be registered:	
Utility account number (optional):	
Address of the customer or applicant in whose name the utility account is or will be registered:	
Name and address of patient if different from the customer or applicant above:	
Relationship of patient to customer or applicant if patient is different from the customer or applicant above:	

**PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN'S ASSISTANT INFORMATION**

Anticipated length of the affliction/medical condition:	
Printed name of the Physician, Nurse Practitioner, or Physician's Assistant:	
License number of the Physician, Nurse Practitioner, or Physician's Assistant:	
Office address and Office Phone number of the Physician, Nurse Practitioner, or Physician's Assistant:	
Signature (or E-signature) of the Physician, Nurse Practitioner, or Physician's Assistant:	
Signature:	Date:

Please send completed Medical Certificate back to Aqua within 3 Business Days  
 Fax: 866-780-8301  
 Email: [nationalcollections@aquaamerica.com](mailto:nationalcollections@aquaamerica.com)  
 Mail: 762 W Lancaster Ave  
 Attn: Collections Department  
 Bryn Mawr, PA 19010