FORM SB 998 A

CERTIFICATION OF PRIMARY CARE PROVIDER

NICE MUTUAL WATER COMPANY

THIS SECTION TO BE FILLED OUT BY ACCOUNT HOLDER

Account Number

Service Address

Account Holder Name

Person Receiving Primary Care

Date of bill seeking Payment Arrangment

Amount of bill seeking Payment Arrangement

I, the acount holder, certify under penalty of perjury that the above named person reciving care resides at the service address.

Account Holder Signature

Phone Number

THIS SECTION TO BE FILLED OUT BY PRIMARY CARE PROVIDER

Name of Primary Care Provider

Name of Clinic or Medical Facillity

Clinic Address

Clinic Phone Number

National provider Identifier

Person Receving Primary Care

I, the primary care provider, certify under penalty of perjury that I provide care to the above named person and that discontinuation of water service to this person would pose a serious threat to his/her health and saftey.

Primary Care Provider Signature

THIS SECTION TO BE FILLED OUT BY NICE MUTUAL WATER COMPANY STAFF