ALDERWOOD
WATER & WASTEWATER
DISTRICT

3626 - 156th Street SW • Lynnwood, WA 98087-5021 • 425-743-4605 • 425-742-4562 Fax • www.awwd.com

Licensed Physician Statement of Disability

APPLICANT

Name_____ Account #_____

Service Address_____

Phone #_____ Email_____

PHYSICIAN

Only the following professional classifications are authorized to sign on behalf of Applicant: Physician & Surgeon – MD or DO, Podiatrist – DPM, Naturopath – ND, Advanced Registered Nurse Practitioner – ARNP, Physician's Assistant – PA

Physician Name _____

Business Name and Address _____

_____

Professional Classification _____

Phone #_____ Email_____

I certify that my patient _____ is permanently disabled. My findings have been confirmed through physical examination and medical history. This disability is expected to be long-continued and of indefinite duration.

I certify under penalty of perjury, under the laws of the State of Washington, that the foregoing is true and correct.

Signature_____

Date_____