COLTON PUBLIC UTILITIES
APPLICATION FORM
MEDICAL NEED FOR AIR CONDITIONING

Applicable for residential occupants with Multiple Sclerosis, Paraplegia, Quadriplegia, Scleroderma, or other conditions that a physician determines the need for air conditioning or space heat is medically necessary to sustain the life of the person or prevent deterioration of the person's medical condition.

_____ _____
Customer Name Customer Utility Account Number

_____ _____
Service Address Home Phone Number

_____ _____
City Zip Code Business Phone Number

_____
Name of person(s) with medical condition

_____
Type of medical condition

_____
NAME OF PHYSICIAN OR OSTEOPATH LICENSED TO PRACTICE MEDICINE INTHE STATE OF CALIFORNIA (Attach to this application a letter from practicing
Physician or Osteopath stating patient's medical condition. Physician's phone number
and business address should be included in letter.

Type of Air Conditioning Equipment: _____ _____
Energy Source Equipment Type

Type of Space Heating Equipment: _____ _____
Energy Source Equipment Type

NOTE TO THE APPLICANT:
A REPRESENTATIVE FROM COLTON PUBLCI UTILITIES MAY CALL FOR AN APPOINTMNET AND VERIFY THE EXISTENCE AND TYPE OF ELECTRIC AIR CONDITIONING EQUIPMENT AND/OR ELECTRIC HEATING EQUIPMENT.

THE DISCOUNT ON YOUR UTILITY BILL WILL OCCUR WITHIN 30 DAYS OF VERIFICATION.

CITY USE ONLY

DATE OF VERIFICATION_____

VERIFICATION COMMENTS:
_____
_____

ADDITIONAL kWh/DAY ALLOWED IN LOW BLOCK RATE:
_____REFER TO AIR CONDITIOING/SPACE HEATING ALLOTMENT SHEET

_____
DEPARTMENT REPRESENTATIVE SIGNATURE