ANTIOCH
CALIFORNIA

CERTIFICATION OF PRIMARY CARE PROVIDER
FORM 998-A

ACCOUNT HOLDER INFORMATION The section below to be filled out by the City of Antioch Water Account Holder	
ACCOUNT NUMBER	**SERVICE ADDRESS**
ACCOUNT HOLDER NAME	**PERSON RECEIVING PRIMARY CARE**

ACCOUNT HOLDER CERTIFICATION

I, the account holder, certify under penalty of perjury that the above-named person receiving primary care resides at the service address. I understand this information must be recertified annually.

Account Holder Signature

PRIMARY CARE PROVIDER CERTIFICATION The section below to be filled out by the Primary Care Provider	
PATIENT NAME	**NAME OF PRIMARY CARE PROVIDER**
CLINIC NAME	**CLINIC ADDRESS**
CLINIC PHONE NUMBER	**NATIONAL PROVIDER IDENTIFIER**

PRIMARY CARE PROVIDER CERTIFICATION

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 or her health and safety.

Primary Care Provider Signature

Physician Stamp

Date

FOR OFFICE USE ONLY		
DATE AND TIME RECEIVED	**RECEIVED BY**	**COMPLETE?**