



REQUEST FOR ADJUSTMENT TO DROUGHT WATER ALLOCATION
(Medical/Change in Occupancy)

Customer Name: Last Name First Name

Account Number: Email Address:

Service Address:

Mailing Address:

Home phone Work phone Cell phone

Adjustment Requested (check at least one and submit applicable information):

Substantiated medical requirements

The undersigned medical doctor hereby certifies that following person(s) who reside(s) at the address listed above has a medical condition(s) that require(s) the use of gallons of water per day above and beyond regular water usage.

Name: Medical Doctor

Date:

Change in occupancy

Note the number of occupants below (do not include temporary visitors)

2005 2006 2007 current

I certify under penalty of perjury that all the information provided on this declaration is truthful and correct. I understand that all information provided is subject to verification by EBMUD and may include an audit of water use including an inspection by EBMUD of the interior and exterior of my premises.

Customer Signature

Date

Allocation Adjustment requests should be sent to:

Allocation Adjustment Request, MS 001
EBMUD
PO Box 24055
Oakland CA 94623

Email: water.allocation@ebmud.com
Fax: 1-866-726-5119
Questions? Call 1-866-40-EBMUD

Please allow up to three weeks for a response.

Table with 4 columns: EBMUD Staff Auditor, For District Use Only, Accepted, Denied, Date.