WATER CONSERVATION HEALTH EXEMPTION REQUEST FORM

Date: _____

Name: _____

Address: _____

_____

Phone: _____

FOR OFFICE USE ONLY:

APPROVED BY: _____

DENIED BY: _____

AN APPROVED EXEMPTION IS VALID FOR A 8 MONTH PERIOD, STARTING ON MARCH 1 AND EXPIRING OCTOBER 31.

Address of Requested Exemption: _____

Reason for Exemption_____

_____

_____

You must attach a doctor's note or prescription form verifying the disability. You may FAX the application and/ or RX form to 559-685-2378.

Signature of Applicant: _____

Please return completed form to:

City of Tulare
Water Division
3981 S "K" Street
Tulare, CA. 93274