



Priority Suspend Service Form

Date of Request: _____

Resident's Name: _____

Address: _____

Telephone Number: _____

Date Service Should Cease: _____

Date Service Should Resume: _____

***Note: Requests are for a minimum of 30 days and a maximum of 90 days and credits will be given for FULL calendar months only

Signature of Resident: _____

IMPORTANT

In order for your exemption request form to be considered, the above information must be complete, and the form must be signed and dated at the time of submittal.

_____ ***DO NOT WRITE BELOW THIS LINE*** _____

Checkmarks denote the month credits will be received:

Year: _____

Jan _____ Feb _____ March _____ April _____ May _____ June _____

July _____ Aug _____ Sept _____ Oct _____ Nov _____ Dec _____

Year: _____

Jan _____ Feb _____ March _____ April _____ May _____ June _____

July _____ Aug _____ Sept _____ Oct _____ Nov _____ Dec _____