PHYSICIAN CERTIFICATION OF SERIOUS ILLNESS OR LIFE SUPPORT

This is to certify that _____ is a resident of:

Street Address: _____
City, State, Zip: _____

Telephone Number: _____
Relationship to Customer _____
Account Number: _____

THIS SECTION IS TO BE COMPLETED BY A LICENSED PHYSICIAN ONLY

I hereby certify that termination of electric and/or gas service will either (check applicable box or boxes):

☐ **aggravate an existing serious illness* or**

☐ **prevent the use of life support equipment by the person named above.****

(Please print)
Physician's Name _____

License No. _____

Title _____

Address _____

_____

Office Number _____**Fax Number**_____

E-Mail Address (optional) _____

Physician's signature _____Date _____

This medical certificate is only valid for a period not to exceed 30 days.

* "Serious illness" means an illness certifiable by a licensed physician to be such that termination of service during the period of time covered by the certificate would be especially dangerous to the health of the person certified to be seriously ill.
**"Life-support equipment" means any electric or gas energy-using device certified by a licensed physician as being essential to prevent, or to provide relief from, a serious illness or to sustain the life of the customer or an occupant of the premises.