Physician Certification of Serious Illness or Need For Life Support*

This is to certify that

Name of person with illness: ______________________________

Resides at: ______________________________ County: ______________

City: ______________________________ State: ________ Zip code: ______________

Is this patient a utility customer? ☐ Yes ☐ No

If not, what is relationship to the customer? ______________________________

THIS SECTION IS TO BE COMPLETED BY A LICENSED PHYSICIAN ONLY

Circle one:
I hereby certify that termination of ELECTRIC / TELEPHONE / WATER / GAS
service will: (check box(es) that apply)

☐ aggravate an existing serious illness, possibly resulting in worsening of condition and severe acute illness to the health of the person named above.

☐ prevent the use of life support equipment by the person named above resulting in possible death. Life support equipment refers to any electric or gas energy-using device determined by this person's licensed physician as being essential to prevent or provide relief from a serious illness or to sustain the life of the customer or occupant of the premises.

Name of Utility Company: ______________________________ Account No.: ______________

Physician's name: (please print) ______________________________

License No. ______________________________

Title: ______________________________

Office Address: ______________________________

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Office phone: ______________________________ Fax: ______________________________

Email address: ______________________________

Physician's signature: ______________________________ Date ______________

Person with illness signature: ______________________________ Date ______________

**Some utility providers will require completion of their own documentation.*