PRIORITY ACCOUNT MEDICAL DOCUMENTATION FORM

~Please Print or Type~

Priority Accounts are those where an occupant of the dwelling is so ill that termination of service would adversely affect his/her recovery as certified by a statement in writing from either a duly licensed physician in Delaware or any accredited Christian Science Practitioner.

NAME AND ADDRESS OF PERSON WHO IS SO ILL THAT TERMINATION OF SERVICE WOULD AFFECT HIS/HER HEALTH OR RECOVERY:

_____

_____

LIST TYPE OF MEDICAL EQUIPMENT REQUIRED:

_____

_____

_____

NUMBER OF AMPERES (AMPS) OF POWER REQUIRED TO OPERATE LISTED MEDICAL EQUIPMENT _____ **AMPERES (AMPS).** If medical equipment requires more than 10 (AMPS), provide either: a copy of the medical equipment's specifications or the model name and number and the manufacturer's name and address.

INDICATE THE TIME FRAME FOR WHCH THE MEDICAL EQUIPMENT WILL BE REQUIRED:

_____

LIST THE UTILITIES (e.g. water and/or electric)**, IF ANY, REQUIRED TO OPERATE THE MEDICAL EQUIPMENT:** _____

~Please Print or Type~

DOCTOR'S NAME: _____

DOCTOR'S ADDRESS: _____

DOCTOR'S TELEPHONE NUMBER: _____

_____ _____

Doctor's Signature Date

<u>This notice is only valid for a period of 120 days</u>. It is the responsibility of the customer to renew this notice. Failure to renew this notice may result in termination of water and/or electric service without further notice.

_____ _____

Customer's Signature Date

Daytime Telephone Number: _____ **Account Number:** _____