



P.O. Box 1130
Clayton, DE 19938-1130
(302) 653-8419 – Office
(302) 653-2017 - Fax

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 WHICH 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

This notice is only valid for a period of 120 days. 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:** _____