Life Support Certification Form

City of Newark
220 S. Main Street
Newark, Delaware 19711
Customer Service (302)366-7000 Fax (302)366-7169

CUSTOMER NAME: _____

ACCOUNT# _____ PHONE# _____

SERVICE ADDRESS: _____

_____

NAME OF THE PERSON REQUIRING MEDICAL ATTENTION (If not the responsible for the bill, please list your relationship to the individual below): _____

*Relationship to the above individual: _____

PHYSICIAN CERTIFICATION

TYPE OF EQUIPMENT PRESCRIBED AND MINIMUM POWER REQUIREMENTS: (Listed on equipment) _____

CAN EQUIPMENT BE MANUALLY OPERATED? _____YES _____NO

IS AN ALTERNATE POWER SOURCE AVAILABLE? _____YES _____NO

PHYSICIAN'S NAME: _____

PHYSICIAN'S PHONE#: _____

_____ _____
PHYSICIAN'S SIGNATURE DATE

I UNDERSTAND THAT HAVING A MEDICAL PRIORITY STATUS ON MY ACCOUNT DOES NOT EXCLUDE ME FROM BEING DISCONNECTED FOR DELINQUENCY OR NON-PAYMENT. I ALSO UNDERSTAND THAT THIS FORM CAN NOT PROTECT AGAINST A POWER FAILURE OR MAJOR DISASTER. ***LIFE SUPPORT ACCOUNTS MUST BE CURRENT (WITHOUT AN OVERDUE BALANCE) AT THE TIME OF RENEWAL.***

_____ _____
CUSTOMER SIGNATURE DATE