**Medical Form**

Please give this form to your doctor and return or fax to the above address/number.

|  |  |
| --- | --- |
| Date: |  |
|  |  |
| Patient’s Name: |  |
|  |  |
| Patient’s Address: |  |
|  |  |
| Telephone Number: |  |
|  |  |

*Rules administered by the Public Service Commission PSC 113.0301 (13)(a) prohibit utilities from disconnecting or refusing to reconnect residential electric or water service for up to 21 days if the disconnection or refusal will aggravate an existing medical or protective services emergency. In order to determine if the above customer is eligible for reconnection or a postponement of disconnection for medical reasons, please provide the following information.*

|  |
| --- |
| Please identify and/or describe the patient’s medical condition: |
|  |
|  |
|  |
| Please explain why (electricity/water) is necessary in this situation: |
|  |
|  |
|  |
| Is electricity required to operate medical equipment to sustain life? Yes [ ]  No [ ]  Please explain: |
|  |
|  |
|  |

Name of Doctor/Health Care Professional (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Doctor/Health Care Professional \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Hospital/Clinic/Agency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_