MEDICAL CERTIFICATION FORM

Date:_____

Name of Utility:_____

Account Number:_____

RE: _____ _____
(Patient Name) (Name of Account Holder if different from Patient)

_____
(Patient's relationship to the Account Holder)

_____
(Patient Address)

_____
(Address of Account Holder if Different From Patient)

To Whom it May Concern:

I certify that I have examined the patient named above and, in my professional opinion as a medical doctor, doctor of osteopathy, or nurse practitioner licensed by the State of Pennsylvania, I certify that the patient is seriously ill and /or afflicted with a condition which will be aggravated by cessation of gas service. Therefore, in accordance with state law, kindly protect or restore utility service at this address from shut off. The patient's condition is as follows:_____
_____
_____

The patient requires gas service because:_____

_____

Sincerely,

[signature]

_____
Print name of certifying physician or nurse practitioner

_____
Address of certifying physician or nurse practitioner

_____
Telephone Number