

TOWN OF SMYRNA
PRIORITY ACCOUNT MEDICAL DOCUMENTATION FORM

CONFIDENTIAL

Please Print or Type

Priority Accounts are those where an occupant of the residential dwelling is so ill that termination of service would adversely affect their health or recovery as certified in this form from a duly licensed physician in Delaware. This form must be completed in its entirety to be considered for Priority Account status.

Account Holder's Signature: _____ Account Number: _____

Daytime Telephone Number: _____ Date: _____

Name and address of person who is so ill that termination of service would affect their health or recovery:

Relationship to the account holder: _____

Condition Requiring Priority: _____

Type of Medical Equipment: _____

Number of Amperes (AMPS) of power required to operate listed medical equipment: _____

AMPERES. If the 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.

Central and/or window air conditioning units and/or central and/or space heating units are not considered life support equipment.

Indicate the time frame for which the medical equipment will be required:

List the utilities, if any, required to operate the medical device: (e.g. electric and/or water)

~PLEASE PRINT OR TYPE~

Attending Physician: _____

Attending Physician's Address: _____

Attending Physician's Telephone Number: _____

Attending Physician's Signature: _____ Date: _____

This notice is only valid for a period of up to one year. It is the customer's responsibility to renew this notice. Failure to renew this notice may result in termination of electric and/or water service without further notice.