

DATE: _____

This is to certify that: _____ who resides at

_____ has in regular use a (an) _____

In my opinion, the above mentioned individual is dependent on this equipment _____ hours

per day _____ days per week. This equipment does / does not have a backup and
(circle one)

can / cannot be operated manually. If applicable, backup will provide _____ hours of operation.
(circle one)

PLEASE CHECK ONE:

1. _____ **WOULD BE PLACED IN IMMEDIATE LIFE-THREATENING EMERGENCY**
2. _____ would not be placed in immediate danger, however, the individual should have a
back up plan for extended power outages.

DATE OF LAST OFFICE VISIT: _____ DR.'S TELEPHONE NUMBER: _____

DR.'s NAME: _____
(please print, Must be able to read name)

Dr's Address: _____

Dr's. SIGNATURE: _____

LICENSED: _____

PLEASE RETURN THIS FORM TO: MUNICIPAL SERVICES COMMISSION.
216 CHESTNUT STREET
NEW CASTLE DE 19720
302-323-2335
FAX: 323-2337

NOTE: THIS FORM IS VALID FOR 120 DAYS FROM THE ABOVE DATE.