

PRIORITY ACCOUNT
MEDICAL DOCUMENTATION FORM
PLEASE PRINT OR TYPE

Priority Accounts are those where any occupant of the dwelling is so ill that termination of service would adversely affect his/her health or recovery as certified by this statement completed from either a duly licensed physician in Delaware or any accredited Christian Science Practitioner.

PLEASE PRINT ALL INFORMATION

Customer's Name and Account Number: _____

Customer's Address: _____

Customer's Telephone Number: _____

Customer's Signature _____

Name of person who is so ill that termination of service would affect his/her health or recovery:

List type of medical equipment required: _____

Numbers 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.**

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

List the utilities required to operate the medical equipment.

~PLEASE TYPE OR PRINT~

DOCTOR'S NAME: _____

DOCTOR'S ADDRESS: _____

DOCTORS TELEPHONE NUMBER: _____

DOCTOR'S SIGNATURE: _____

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