



**CERTIFICATION OF MEDICAL NEED**

**NOTE TO CUSTOMER AND PATIENT (IF DIFFERENT):** The Medical Provider’s portion of this form must be completed and signed by a licensed physician, physician’s assistant, or nurse practitioner. Once approved by Delmarva, certification will be effective for 120 days.

The Customer and Patient must complete this portion of the form accurately and completely and return the entire completed form to:

**Delmarva Power, Revenue Recovery  
5 Collins Drive, Suite 2133, Carneys Point, NJ 08069  
Fax: 888-254-1239**

**CUSTOMER AND PATIENT CERTIFICATION**

Name of Delmarva Customer(s): \_\_\_\_\_

Delmarva Account No.: \_\_\_\_\_

Address where Delmarva provides service: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Patient residing at above address that requires service: \_\_\_\_\_

**By signing this form, I certify that the Patient listed on this Certification resides full-time at this address and requires electric or gas for medical need. I understand that I, as the customer, am still responsible for the charges that accrue on my electric and/or gas account and that Medical Alert status does not alleviate my responsibility to make payments on my account.**

**I also understand that participation in Delmarva Power’s Medical Alert Program is voluntary. All of the information disclosed on this form, including the medical information given by the medical provider below, is given freely and voluntarily to assist Delmarva with prioritization of medically sensitive customers.**

**I also certify under oath that the information listed on this form is true and correct.**

Customer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature\*\*\*: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*Parent or Guardian signature if Patient is a minor.

## MEDICAL PROVIDER CERTIFICATION

**NOTE TO MEDICAL PROVIDER:** This Certification is required to assist Delmarva Power in determining whether there are special circumstances, as provided by Delaware law, relating to the provision of electric or gas service to the patient listed above. Kindly list the medical equipment in the space below. If no equipment, then indicate in the alternate space the reason for the medical need of electric or gas. Examples of equipment for which electric or gas is medically necessary:

• Infant Apnea Monitor	• Motorized Wheelchair (for Paralysis or where a manual wheelchair is ineffective)
• Ventilator	• Pressure Breathing Therapy
• Respirator	• Aerosol Tent
• Feeding or Infusion Pumps	• Pressure pads and pumps
• Oxygen Concentrator	• Compressor / Concentrator
• Kidney/Hemo/Peritoneal Dialysis Equipment	• Electronic Nerve Stimulator
• Left ventricular assist devices	• Suction Machine
• Iron Lung	• Ultrasonic or Electrostatic Nebulizers <b>(does not include small volume nebulizers or CPAP / Bi-PAP machines)</b>

Name of medical equipment in use (please list all if more than one): \_\_\_\_\_

If no equipment, please list medical condition requiring electric or gas and give a brief explanation why:

\_\_\_\_\_

Medical Provider's Information (please print legibly):

Name: \_\_\_\_\_

State license (with number): \_\_\_\_\_

Practice and/or specialties: \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_

I, Medical Provider, certify that the patient noted above is under my care, and that person is so ill that the termination of electric or gas service WOULD adversely affect his/her health or recovery. I acknowledge that, by signing this, I may be called to testify in any proceeding brought by Delmarva which challenges the validity of this patient's medical need. I also certify under oath that the information provided by me herein is true and accurate to the best of my knowledge, information and belief and that the address listed above as the primary residence for the patient matches the address listed in my files.

Signature of Medical Provider: \_\_\_\_\_ Date: \_\_\_\_\_