

**Town of Clayton  
Medical Alert Program**

**Medical Certification Form**

*Customer Information to be Completed by Customer:*

Name \_\_\_\_\_ Account Number \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Account Address \_\_\_\_\_

Patient's Name \_\_\_\_\_

Please read the following and initial each one:

\_\_\_ I certify that the patient named above is a member of my household residing at the above address.

\_\_\_ I understand that this Certificate will expire on December 31, 2011 and must be resubmitted annually by this date to continue participating in the Medical Certification Program.

\_\_\_ I further understand that this in no way releases me from my obligation to pay my monthly bill in accordance with the Town of Clayton's standard payment terms.

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***Section to be completed by a Licensed Healthcare Provider***

I hereby certify that my patient, \_\_\_\_\_, has a chronic or critical health issue and should be afforded priority consideration for restoration of electric service in the event of an outage.

Name of Licensed Healthcare Provider \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_