TOWN OF SMYRNA

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 assistant or advanced nurse practitioner. Once approved by Town of Smyrna, certification will be effective for 365 days.

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

Town of Smyrna
27 S Market Street Plaza, Smyrna, DE 19977
Fax: 302-653-3492

CUSTOMER AND PATIENT CERTIFICATION

Name of Town of Smyrna Customer(s): _____

Town of Smyrna Account Number: _____

Address where Town of Smyrna provides service: _____

City: _____ State: _____ Zip code: _____

Phone number: _____

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 for medical need. I understand that I, as the customer, am still responsible for the charges that accrue on my electric account and that Medical Alert status does not alleviate my responsibility to make payments on my account. I further understand that, if approved, this Certification is effective for 365 days.

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

Robert C. Johnson, Mayor

D. Barrett Edwards IV, Attorney

TOWN OF SMYRNA

MEDICAL PROVIDER CERTIFICATION

NOTE TO MEDICAL PROVIDER: This Certification is required to inform the Town of Smyrna that termination of the sale or service of electricity to the patient listed above will adversely affect the health or recovery of that patient.

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 WOULD adversely affect their health or recovery. I acknowledge that, by signing this, I may be called to testify in any proceeding brought by Town of Smyrna 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: _____

27 SOUTH MARKET STREET PLAZA | P.O. BOX 307 | SMYRNA, DELAWARE 19977

BUSINESS OFFICE/BILLING 302-653-9231
Fax 302-653-3492

MANAGER'S OFFICE 302-653-9231
Fax 302-653-3492

PERMITS/INSPECTIONS 302-653-3486
Fax 302-659-4169