**STANDARD MEDICAL CERTIFICATE FORM**

|  |
| --- |
| **Name of the customer or applicant in whose name the utility account is or will be registered:** |
| **Utility account number (optional):**  |
| **Address of the customer or applicant in whose name the utility account is or will be registered:****Name and address of patient if different from the customer or applicant above:****Relationship of patient to customer or applicant if patient is different from the customer or applicant above:** |
| **Anticipated length of the affliction/medical condition:** |
| **Printed name of the Physician, Nurse Practitioner, or Physician’s Assistant:** |
| **License number of the Physician, Nurse Practitioner, or Physician’s Assistant:** |
| **Office address and Office Phone number of the Physician, Nurse Practitioner, or Physician’s Assistant:** |
| **Signature (or E-signature) of the Physician, Nurse Practitioner, or Physician’s Assistant and the Date signed:**  |

**To Be Completed By The Physician, Nurse Practitioner, or Physician's Assistant**