COLUMBUS LIGHT AND WATER

MEDICAL FORM FOR CERTIFICATION OF USE OF LIFE-SUSTAINING ELECTRIC DEVICE (vers 11/1/18)

ALL SECTIONS MUST BE COMPLETED IN ORDER TO PROCESS THIS CERTIFICATION

☐ THIS IS THE FIRST TIME I'VE REQUESTED A CERTIFICATION ☐ THIS IS AN ANNUAL RENEWAL

CUSTOMER NAME ON ACCOUNT:____

SERVICE ADDRESS:____

LOCATION NO.______________________________CUSTOMER NO.___________________________

PHONE NUMBER (____) ____

NAME OF PERSON RESIDING AT SERVICE ADDRESS
WITH MEDICAL CONDITION ____

RELATIONSHIP TO CL & W CUSTOMER ____

STATEMENT OF LICENSED PHYSICIAN

By my signature below, I certify that my records indicate that ___________________________________, who is currently under my care, resides at the above referenced household. I further certify that the discontinuance of electric utility service to this household **would create an immediate medical emergency and would result in death.**

Type of medical equipment ____

Length of time condition expected to last _______________________________________

(PLEASE PRINT)

NAME OF LICENSED PHYSICIAN ____

BUSINESS ADDRESS ____

BUSINESS TELEPHONE ____

CURRENT STATE LICENSE OR CERTIFICATE NUMBER __________________________________

AUTHORIZED SIGNATURE ____

DATE ____

IN CASE OF NON-PAYMENT, THIS CERTIFICATION, IF APPROVED, WILL ALLOW A 30-DAY EXTENSION OF THE TIME TO PAY THE CURRENT COLUMBUS LIGHT AND WATER BILL BEYOND THE DUE DATE AS PRINTED ON THE CURRENT, UNPAID BILL. THIS SPECIAL EXTENSION MAY ONLY BE USED ONE TIME DURING THE CALENDAR YEAR. FURTHERMORE, THIS CERTIFICATION DOES NOT REMOVE THE OBLIGATION TO PAY FOR SERVICES RECEIVED OR TO BE RECEIVED FROM COLUMBUS LIGHT AND WATER.

Bring this completed form to a Customer Service Representative at 420 4th Avenue or mail it to PO Box 949, Columbus, MS 39703.

OFFICE USE ONLY - DATE SENT TO WAREHOUSE: ______________________