



A PHI Company

**PHYSICIAN CERTIFICATION OF SERIOUS ILLNESS OR LIFE SUPPORT**

This is to certify that \_\_\_\_\_ is a resident of:

Telephone Number: \_\_\_\_\_

Relationship to Customer \_\_\_\_\_

**THIS SECTION IS TO BE COMPLETED BY A LICENSED PHYSICIAN ONLY**

**I hereby certify that termination of electric and/or gas service will either (check applicable box or boxes):**

- aggravate an existing serious illness \* or**
- prevent the use of life support equipment by the person named above.\*\***

(Please print)

**Physician's Name** \_\_\_\_\_

**License No.** \_\_\_\_\_

**Title** \_\_\_\_\_

**Address** \_\_\_\_\_

\_\_\_\_\_

**Office Number** \_\_\_\_\_ **Fax Number** \_\_\_\_\_

**E-Mail Address (optional)** \_\_\_\_\_

**Physician's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**This medical certificate is only valid for a period not to exceed 30 days.**

\* "Serious illness" means an illness certifiable by a licensed physician to be such that termination of service during the period of time covered by the certificate would be especially dangerous to the health of the person certified to be seriously ill.

\*\*"Life-support equipment" means any electric or gas energy-using device certified by a licensed physician as being essential to prevent, or to provide relief from, a serious illness or to sustain the life of the customer or an occupant of the premises.