PHYSICIAN'S CERTIFICATION FORM
MEDICAL EMERGENCY CUSTOMER STATUS

Please complete all the information requested below under "CUSTOMER" and then forward it to your physician. Your physician should complete the section below under "PHYSICIAN" and FAX or MAIL the completed form back to ASHLAND ELECTRIC DEPT. Thank you for your cooperation.

CUSTOMER INFORMATION

Date_______________ Customer Name____

Customer Mailing Address____

City____ State__________ Zip__________

Ashland Electric Dept. Account Number______________________

Telephone Number (_____)__________________

Name and Relationship of Person with Medical Condition: ______________________//__________

I hereby authorize the release of medical information necessary for the completion of this physician's certification of medical condition form:

Signature: ______________________________

TO BE COMPLETED IN FULL BY PHYSICIAN

The above customer has applied to Ashland Electric Dept. for participation in the Medical Emergency Program because he/she or someone within their household is suffering from a medical condition, which would result in a medical emergency if electrical service were disconnected. Ashland Electric Dept. will consider this account to be in "Medical Emergency Status" provided you, as a registered physician, certify in writing that this patient is suffering from such a medical condition.

Date_______________ Patient's Name____

Description of Medical Condition____

Would disconnection of electric service result in a medical emergency? _____ Yes _____ No

Projected Length of Medical Condition____

Physician's Name and Address____

Physician's Telephone Number (_____) __________________

Physician's Signature ____________________________ Provider's State License No.____________

Physicians...Please Note: Complete and return this form within seven (7) days

Mail to Ashland Electric Dept., 6 Collins Street, Ashland, NH 03217 or FAX to (603) 968-9048