**STANDARD MEDICAL CERTIFICATE FORM**

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| **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**