# Physician's Certification
# Medical Condition

Dear Unitil Customer:

Unitil needs you and your doctor to fill out this form in order to qualify for account protection* or to be identified as a Life Support Customer. Please fill in all of the information under "CUSTOMER" and then give this form to your doctor. The doctor should complete the section under "PHYSICIAN" and FAX or MAIL the completed form back to Unitil from their office. Thank you for your cooperation.

## CUSTOMER

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|---|---|
| **DATE:** | **CUSTOMER OF RECORD:** |
| **PATIENT NAME AND RELATIONSHIP TO CUSTOMER (IF DIFFERENT THAN CUSTOMER OF RECORD):** | |
| **CUSTOMER SERVICE ADDRESS:** | |
| **CITY:** **STATE:** **ZIP:** **Email:** | |
| **UNITIL ACCOUNT #:** **Primary TEL #: ( )** **2nd TEL #( )** | |
| **3rd PARTY CONTACT (Optional) – NAME:** **TEL NUMBER: ( )** | |

*** NOTE: You must also provide low income verification if applicable in addition to this form to get account protection.**

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

| | |
|---|---|
| **CUSTOMER SIGNATURE:** | **DATE:** |

**TO BE COMPLETED IN FULL BY Physician, Physician's Assistant, Nurse Practitioner or local Board of Health**

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|---|---|
| **PHYSICIAN'S NAME:** | **LICENSE NUMBER:** |
| **ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP:** |
| **E-MAIL:** | **TELEPHONE NUMBER: ( )** |

The above customer has told Unitil that he or she or someone within their household is seriously ill, so we will add the appropriate medical flag(s) to this customer's Unitil account based upon the direction that you provide below. Thank you for your cooperation**.**

**Physician Signature:** _____

**Is electrically powered LIFE SUPPORT equipment used?** **Yes:** ☐ **No:** ☐

| | |
|---|---|
| **Date:** | **Patient's Name:** |
| **Nature of the illness:** | |
| **Medical Equipment Being Used:** | |

What is the anticipated length of this condition? **3-Months:** ☐ **6-Months:** ☐ **12-Months:** ☐

**PHYSICIANS: PLEASE FAX OR MAIL THIS FORM FROM DOCTOR'S OFFICE TO UNITIL WITHIN SEVEN (7) DAYS.**

Confidential, Attended **FAX # 603-227-4784**