

**STANDARD MEDICAL CERTIFICATE FORM**

**To Be Completed By The Physician, Nurse Practitioner, or Physician's Assistant**

**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:**