

CERTIFICATION OF MEDICAL NEED

NOTE TO CUSTOMER AND PATIENT (IF DIFFERENT): The Medical Provider's portion of this form must be completed and signed by a licensed physician, physician assistant or advanced nurse practitioner. Once approved by Delmarva, certification will be effective for 120 days.

The Customer and Patient must complete this portion of the form accurately and completely and return the entire completed form to:

Delmarva Power, Revenue Recovery
5 Collins Drive, Suite 2133, Carneys Point, NJ 08069
Fax: 888-254-1239

CUSTOMER AND PATIENT CERTIFICATION

Name of Delmarva Customer(s): _____

Delmarva Account No.: _____

Address where Delmarva provides service: _____

City: _____ State: _____ Zip code: _____

Phone number: _____

Patient residing at above address that requires service: _____

By signing this form, I certify that the Patient listed on this Certification resides full-time at this address and requires electric or gas for medical need. I understand that I, as the customer, am still responsible for the charges that accrue on my electric and/or gas account and that Medical Alert status does not alleviate my responsibility to make payments on my account. I further understand that, if approved, this Certification is effective for 120 days.

I also certify under oath that the information listed on this form is true and correct.

Customer Signature: _____ Date: _____

Patient Signature***: _____ Date: _____

***Parent or Guardian signature if Patient is a minor

MEDICAL PROVIDER CERTIFICATION

NOTE TO MEDICAL PROVIDER: This Certification is required to inform Delmarva Power that termination of the sale or service of electricity or natural gas to the patient listed above will adversely affect the health or recovery of that patient.

Medical Provider's Information (please print legibly):

Name: _____

State license (with number): _____

Practice and/or specialties: _____

Office Address: _____

Office Phone: _____

I, Medical Provider, certify that the patient noted above is under my care, and that person is so ill that the termination of electric or gas service WOULD adversely affect his/her health or recovery. I acknowledge that, by signing this, I may be called to testify in any proceeding brought by Delmarva which challenges the validity of this patient's medical need. I also certify under oath that the information provided by me herein is true and accurate to the best of my knowledge, information and belief and that the address listed above as the primary residence for the patient matches the address listed in my files.

Signature of Medical Provider: _____ Date: _____