MEDICAL PROFESSIONAL CERTIFICATION OF MEDICAL CONDITION REQUIRING REPAIR PRIORITY

THIS SECTION IS TO BE COMPLETED BY CUSTOMER OR CUSTOMER'S AGENT

(Please Print)

This is to certify that _____ [PERSON WITH MEDICAL CONDITION] is a resident of the following household and does not have alternative access to Emergency-911 service (example – does not have a cell phone or another telephone line in the household):

Street Address: _____
City, State, Zip: _____

Name of Telephone Customer/Account Holder (name on telephone account at this household): _____
Telephone Number at this household: _____

Name of Person completing this section: _____

Signature _____Date_____

Relationship to Customer/Account Holder: _____

THIS SECTION IS TO BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL ONLY

I hereby certify that _____ has a serious medical condition that requires 24-hour repair commitments on his or her telephone line (unless he or she has alternative access to Emergency-911 service).

Is this a permanent condition? _____Yes _____ No

Medical Professional's Name _____
License No. _____
Title _____
Address _____
_____

Office Telephone Number _____ Fax Number_____

E-Mail Address (optional) _____

Medical Professional's Signature _____Date_____

This medical certificate is valid for one year from the date above, unless a permanent condition is indicated above, or until such time the account is either closed or a billing name change is made to the account.