



Town of Clayton Medical Alert Program

Medical Certification Form

Customer Information to be Completed by Customer:

Name _____ Account Number _____

Work Phone _____ Home Phone _____ Cell Phone _____

Account Address _____

Patient's Name _____

Please read the following and initial each one:

___ I certify that the patient named above is a member of my household residing at the above address.

___ I understand that this Certificate will expire on December 31 and must be resubmitted annually by this date to continue participating in the Medical Certification Program.

___ I further understand that this in no way releases me from my obligation to pay my monthly bill in accordance with the Town of Clayton's standard payment terms.

Section to be completed by a Licensed Healthcare Provider

I hereby certify that my patient, _____, has a chronic or critical health issue and should be afforded priority consideration for restoration of electric service in the event of an outage.

Name of Licensed Healthcare Provider _____

Signature _____ Date _____