**Request for Medical Certification**

Customer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Customer Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if available)

PWD

|  |
| --- |
| Water Revenue Bureau |
| 1401 JFK BlvdPhiladelphia, PA 19102 |
|  |

**VIA FAX TO: 215-685-3777**

**SERVICE IS NOW** **[ ]  ON** **[ ]  OFF**

Dear Sir or Madam:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_, is a patient at the Center for Child and Adolescent Health at St. Christopher’s Hospital for Children. The patient resides with the customer at the above address. The patient’s relationship to the customer is \_\_\_\_\_\_\_\_.

Nature of illness or medical condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The patient is seriously ill or affected by a medical condition that will be at increased risk of being aggravated by utility service termination or failure to restore service.

The anticipated duration of the illness or condition is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_;

or, the illness or condition is □ chronic □ terminal.

**If chronic or terminal is checked, please process as 6 month medical certification.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Physician’s Name License Number

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature Date Signed

St. Christopher’s Hospital for Children

Center for the Urban Child

160 E Erie Ave

Philadelphia, PA 19134

215.427.5000