**MEDICAL EMERGENCY CERTIFICATION FORM**

ALL Fields are required information and must be completed.

|  |  |
| --- | --- |
| **CUSTOMER NAME:** |  |
| **ACCOUNT NO:** | **SERVICE ADDRESS:**  |
| **PHONE NO:** | **CITY, STATE, ZIP:**  |

***Gas service may be shutoff at your home unless this FORM is COMPLETED & SIGNED BY A MEDICAL PRACTITiONER AND RETURNED TO Peoples BEFORE THE DATE ON THE TERMINATION NOTICE. IF YOU ARE INELIGIBLE FOR A MEDICAL CERTIFICATE, RETURNING THIS FORM WILL NOT PREVENT THE TERMINATION.***

**TO BE COMPLETED BY CUSTOMER**

Afflicted Individual: Relationship to Customer:

Permanent Address of Afflicted:

**TO BE COMPLETED BY A LICENSED PHYSICIAN/ PHYSICIAN ASSISTANT/ NURSE PRACTITIONER**

I certify that in my professional opinion, the following person is seriously ill or has been diagnosed with a medical condition which requires the continuation of natural gas service to treat the medical condition. I understand that I may be contacted to verify the statements contained herein.

Name of Individual:

Nature of Illness: Date of Last Examination:

Specific Reason for which natural gas service is required:

Anticipated Duration of Illness/Medical Condition:\*

Are you a Physician, Physician’s Assistant, or Nurse Practitioner?

Name: License Number:

Office Address & Phone Number:

Medical Practitioner Signature: Date:

**\* This certificate is in effect for the anticipated length of the illness up to a maximum of 30 days.**

**The customer still has the responsibility to make payment arrangements for bills owed to Peoples.**

Return this notice by fax to (855) 269-0090, by e-mail to CustomerCarePeoples@peoples-gas.com, or by mail to PO Box 535323, Pittsburgh, PA 15253-5323. If you have any questions, please call us at (800) 764-0111, Monday through Friday, 7:00 a.m. – 5:00 p.m.

***Peoples Natural Gas use ONLY:***

Date Received\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Received By\_\_\_\_\_\_\_\_\_\_ Date Verified/Entered\_\_\_\_\_\_\_\_\_\_\_\_\_

Payment Arrangements Made (Y/N)\_\_\_\_\_\_\_\_\_\_\_\_\_Expiration Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial or Renewal \_\_\_\_\_\_\_\_\_\_\_\_