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.

The completed form should be mailed to:
Maryland Repair Priority Program
P.O. Box 4846
Trenton, NJ 08650-4846