MEDICAL CERTIFICATION FOR PIEDMONT NATURAL GAS – NORTH CAROLINA

This form should be completed when a physician believes interruption of gas service could be hazardous to the health of the customer or a member of the household as a result of a chronic or serious illness.

IMPORTANT – THIS CERTIFICATION SHALL EXPIRE 1 YEAR FROM THE DATE OF EXECUTION BY THE PHYSICIAN. THIS CERTIFICATION ONLY PREVENTS SERVICE FROM BEING DISCONNECTED DURING THE MONTHS OF NOVEMBER THROUGH MARCH.

Section to be completed by customer

Customer Name	Date
Service Address	Account Number
City State Zip	Name of Patient
Home Phone Number	Relationship to Patient
Work Phone Number	

I certify that the information given above is correct and that the patient named above resides with me at the service address shown above. I also understand that I am responsible for monies owed to Piedmont Natural Gas and must make reasonable payment arrangements when balances are unable to be paid by their due dates.

_____ _____

Customer Signature Date Signed

ALL INFORMATION MUST BE COMPLETELY FILLED OUT BY THE CUSTOMER AND PHYSICIAN, OTHERWISE THIS CERTIFICATION WILL BE CONSIDERED NULL AND VOID BY PIEDMONT NATURAL GAS RESULTING IN POSSIBLE DISCONNECTION OF GAS SERVICE.

Section to be completed by physician

I am a duly licensed physician in the State of _____and my office practice of medicine is located at

_____..

I certify that in my professional opinion the above named patient is seriously ill and afflicted by the following condition which would be hazardous to their health by the absence of gas service:

_____

This condition is: Permanent _____ Temporary _____

If temporary, anticipated length of illness _____

I understand that I may be contacted to provide verification of these statements.

_____ _____

Signature of Physician Date Signed

_____ _____

License Number Office Phone Number