PLWC
ONE TEAM, ONE GOAL... CUSTOMER SERVICE

P.O. Box 9
Paragould, AR 72451

Ph: 870.239.7700
Fax: 870.215.5106
paragould.com

PLWC Annual Medical Certification Form

Instructions:

The following is to be completed by a licensed medical professional and only after you, or someone in your office, has examined the individual whose name appears as the patient on the form below. This form applies only in situations where termination of utility service would be especially dangerous to the health of that individual. If, in your professional opinion an especially dangerous situation does not exist, please do not sign this form.

If you have any questions regarding this form, please contact: PLWC at 870.239.7700

You may fax the completed form to PLWC at 870.215.5106. (Please include a fax cover sheet with Medical Office name)

I certify that, to the best of my knowledge, the information provided below is true.

The following medical information must be certified by one of the following. Please indicate if you are a:

□ licensed physician □ physician assistant
□ clinical nurse specialist □ certified nurse practitioner

Please complete the following. Please print.

I certify that my patient has been examined by me and I have determined the following to be true:

Name of patient: _____

Patient's PLWC Service address: (Street address) _____

Patient's Phone #: _____

Check the box of the applicable condition:

□ This patient suffers from a hazardous medical condition and termination of utility service would be especially dangerous or life-threatening.

□ This patient uses medical or life-supporting equipment and termination of utility service would make operation of that equipment impossible or impractical.

Authorized Signature_____ Date _____

(Please Print) Name of Licensed Medical Professional_____
Business Address _____
Business Telephone_____

All sections must be fully completed in order to process the medical certification request.