CERTIFICATE OF MEDICAL EMERGENCY

Customer Name:_____

Service Location:_____

Mailing Address:_____

LaFollette Utilities (LUB) Account Number:_____

Customer Social Security Number:_____

Person in household with medical condition:_____

Relationship to customer name listed above:_____

STATEMENT OF LICENSED PHYSICIAN

By my signature, given below, I certify that my records indicate that:

_____

who is currently under my care, resides at the above referenced household. I further certify that the discontinuance of electric utility service to this household would create a medical emergency and possible death.

SIGNED_____**DATE**_____

PRINT NAME_____**PHONE NUMBER ( )**_____

NOTE: THIS STATEMENT DOES NOT IN ANY WAY REMOVE THE OBLIGATION TO PAY FOR SERVICES RECEIVED OR TO BE RECEIVED FROM LAFOLLETTE UTILITIES (LUB).