DUQUESNE LIGHT CO.

REQUEST FOR MEDICAL CERTIFICATION
Solicitud De Un Certificado Medico

CUSTOMER NAME: _____ **ACCOUNT NO. (optional):** _____

Service Address: _____ **Telephone:** _____

City, State, Zip _____

TO BE COMPLETED BY CUSTOMER

NAME OF PERSON WITH SERIOUS ILLNESS OR
MEDICAL CONDITION REQUIRING ELECTRIC SERVICE: _____

ADDRESS OF SERIOUSLY ILL PERSON _____

RELATIONSHIP TO CUSTOMER: _____

STATUS OF ELECTRIC SERVICE: ☐ **ELECTRIC ON** ☐ **ELECTRIC OFF**

MEDICAL CERTIFICATION

I certify that the person named below is seriously ill or is diagnosed with a medical condition requiring the continuation of electric service to treat the medical condition.

PATIENT'S NAME: _____

EXPECTED DURATION OF ILLNESS: _____

_____ _____
SIGNATURE LICENSE NUMBER

LICENSED PHYSICIAN ☐ PHYSICIAN'S ASSISTANT ☐ NURSE PRACTITIONER ☐

_____ _____
PRINT NAME DATE

_____ _____
OFFICE ADDRESS TELEPHONE NUMBER

RETURN COMPLETED FORM TO: **DUQUESNELIGHT.COM/UPLOAD**

OR

DUQUESNE LIGHT COMPANY
DEPARTMENT 6-1
411 7TH AVE STE 3
PITTSBURGH, PA 15219

OFFICE USE ONLY:

DATE RECEIVED: _____

BY **UPLOAD** ☐ **MAIL** ☐

NOTE: MAILED SUBMISSIONS MAY TAKE LONGER TO PROCESS DUE TO POSTAL DELIVERY TIMES. DOCUMENT REVIEW BEGINS ONCE THE FORM IS RECEIVED BY DLC.