



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
CON-L1
100 S. COMMONS, STE. 118
PITTSBURGH, PA 15212

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.