

**MEDICAL PROFESSIONAL CERTIFICATION OF MEDICAL CONDITION
REQUIRING REPAIR PRIORITY**

**THIS SECTION IS TO BE COMPLETED BY CUSTOMER OR CUSTOMER'S
AGENT**

(Please Print)

**This is to certify that _____ [PERSON WITH
MEDICAL CONDITION] is a resident of the following household:**

Street Address: _____
City, State, Zip: _____

**Name of Telephone Customer/Account Holder (name on telephone account at this
household):** _____
Telephone Number at this household: _____
Telephone Account Number: _____

**Does the person with the medical condition have alternative access to E-911?
(example: is there a cell phone or another telephone line in the household?)**
_____ Yes _____ No

Name of Person completing this section: _____
Relationship to Customer/Account Holder: _____

**THIS SECTION IS TO BE COMPLETED BY A LICENSED MEDICAL
PROFESSIONAL ONLY**

**I hereby certify that _____ has a serious medical condition that
requires 24-hour repair commitments on his or her telephone line (unless he or she
has alternative access to E-911 service).**

Is this a permanent condition? _____ Yes _____ No

Medical Professional's Name _____
License No. _____
Title _____
Address _____

Office Telephone Number _____ **Fax Number** _____

E-Mail Address (optional) _____

Medical Professional's Signature _____ **Date** _____

**This medical certificate is valid for one year from the date above, unless a
permanent condition is indicated above, or until such time the account is either closed
or a billing name change is made to the account.**

CERTIFICATION OF SENIOR STATUS FOR REPAIR PRIORITY

THIS FORM IS TO BE COMPLETED BY THE CUSTOMER OR CUSTOMER'S AGENT

(Please Print)

This is to certify that _____ [SENIOR] is a resident of the following household:

Street Address: _____

City, State, Zip: _____

Name of Telephone Customer/Account Holder (name on telephone account at this household): _____

Telephone Number at this household: _____

Telephone Account Number: _____

Senior's Age: _____

Does the Senior have alternative access to E-911? (example: is there a cell phone or another telephone line in the household?) _____ **Yes** _____ **No**

I hereby swear or affirm, and certify, that the person named above is 65 years of age or older, does not have alternative access to E-911 service, and therefore requires 24-hour repair commitments on his or her telephone line.

Name of Person completing this form: _____

Relationship to Customer/Account Holder: _____

Address _____

Telephone Number _____

E-Mail Address (optional) _____

Signature _____ **Date** _____

This certificate is valid until such time the account is either closed or a billing name change is made to the account.