



Certification of Existence of Medical Condition

Energy Assistance Client Name: _____

Patient Name: _____

Service Address: _____

Dear Licensed Health Care Professional:

The above named patient/client indicates that a medical exception exists in his/her household which requires uninterrupted hot water service to the address above. Our programs require your certification that the absence of hot water will aggravate an existing medical condition of a permanent resident of the household.

I HEREBY CERTIFY THAT A MEDICAL CONDITION EXISTS FOR THIS PATIENT AND THAT LACK OF HOT WATER SERVICE IN HIS/HER HOUSEHOLD WILL AGGRAVATE AN EXISTING MEDICAL CONDITION.

Name of Licensed Health Care Professional (Print): _____

Signature of Licensed Health Care Professional: _____

Date: _____

Office Address: _____
(City) (State) (Zip Code)

Office Phone Number _____

