

**Town of Clayton
Medical Alert Program**

Section to be completed by Customer:

Customer Name: _____

Address: _____

Account Number: _____



Section to be completed by Physician or Hospital:

I hereby certify that my patient _____
Insert Patient Name

has a chronic or critical health issue and should be afforded priority consideration for

restoration of electric service in the event of an outage.

Date: _____

Name of Physician or Hospital: _____

Signature: _____