CITY OF BASTROP
MEDICAL ASSISTANCE REQUIRED

Date:_____

Please take notice that _____ is a medical patient requiring electrical power for the proper operation of the follow equipment:_____ or cannot be without power for the following reason:

_____

In the event of an interruption of electrical service, your prompt attention to restore power is greatly appreciated.

The electric service is in the following name(s) and address:

_____ _____
Name Street Address

_____
Phone Number

Physician Approval: _____
Physician Signature

_____ _____
Physician Printed Name Physician Address

_____
Physician Office Phone

This completed form is required for inclusion on the emergency list during power outages. This form expires 12 months from completed date.

UTILITY OFFICE USE: Acct # _____ Date Received:_____