

# REQUEST FOR MEDICAL WAIVER

Tariff provision R460.147 allows for **postponement of shut off or temporary service restoration** for a medical emergency of not more than 21 days if the customer or a member of the customer's household has a certified medical emergency. A medical emergency exists if the customer/household member has a condition that will be aggravated by the lack of gas service. A medical emergency is defined and certified by a physician or public health official. Extensions for further periods of not more than 21 days are granted only if the customer provides additional physician or public health official certification. Total postponement/restoration shall not exceed 63 days in a 12 month period per household member. Shutoff extensions are limited to 126 day in a 12 month period per household.

**I. CUSTOMER CERTIFICATION: (To be completed by customer)**

Customer Name: \_\_\_\_\_ Account No: \_\_\_\_\_  
Customer Address: \_\_\_\_\_  
City, ST, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Household member(s) with \_\_\_\_\_  
medical emergency: \_\_\_\_\_  
Relationship to Customer: \_\_\_\_\_

**II. RELEASE: (to be completed by Resident requiring life-sustaining equipment or his/her legal guardian)**

I, \_\_\_\_\_, (circle one: resident / legal guardian) hereby grant my consent to the below-named licensed physician to release to Michigan Gas Utilities such information as noted below, plus any supplemental information regarding critical medical equipment used at the residence.

Signature of Resident or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**III. MEDICAL VERIFICATION: (To be completed and signed by a licensed physician)**

**A phone number is required so we may contact you for potential clarification and/or verification.**

I, \_\_\_\_\_, a licensed physician, declare there is a medical  
(Print Name)  
emergency requiring **natural gas** for the above named customer/household member.

Required Critical Natural Gas Equipment:  Furnace  Water heater  Other: \_\_\_\_\_

Duration of Medical Emergency  
(maximum 21 days) \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Business Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_

City, ST, Zip \_\_\_\_\_

**Return this form to:** Michigan Gas Utilities **OR** Fax: 308-630-9709  
PO Box 2176  
Scottsbluff, NE 69363

