Date: [Date]

To: [Utility Company Name]
Department: Medical Necessity/Critical Care Registry
Account Number: [Your Account Number]

RE: MEDICAL CERTIFICATION FOR PRIORITY SERVICE RESTORATION

To Whom It May Concern,

I am the primary healthcare provider for **[Patient Name]**, residing at **[Patient Address]**. This letter serves as formal medical certification that the aforementioned individual requires continuous electricity to operate life-sustaining Intravenous (IV) Therapy equipment.

The patient utilizes the following medical device(s):
Equipment: [e.g., Electronic Infusion Pump / IV Syringe Driver]
Usage: [e.g., Continuous 24-hour infusion / Intermittent daily cycles]

The equipment is medically necessary for the administration of [e.g., total parenteral nutrition / life-sustaining medication / hydration]. A loss of power would interrupt this delivery, resulting in a life-threatening medical emergency or immediate hospitalization.

We request that this household be placed on your "Critical Care" or "Priority Restoration" registry. In the event of a scheduled or unscheduled power outage, please provide advance notification and prioritize the restoration of service to this address.

This certification is valid for [Number] months/years. If you require further documentation or have a specific form for completion, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

Physician Name: [Name]
Medical License #: [Number]
Facility Name: [Clinic/Hospital Name]
Phone: [Phone Number]