

**REQUEST FOR PRIORITY SERVICE
FROM
THE CITY OF RENSSELAER**

DATE _____

CUSTOMER NAME, ADDRESS AND PHONE NUMBER:

(____) _____

PHYSICIANS NAME OR LICENSED PUBLIC HEALTH OFFICIAL:

WHY WOULD THE LOSS OF ELECTRIC SERVICE THREATEN THE HEALTH OF
SOMEONE RESIDING IN YOUR HOME?

(example: receiving oxygen, infant monitor, etc.)

PHYSICIAN/PUBLIC HEALTH OFFICIAL SIGNATURE

ALL CUSTOMERS ARE REQUIRED TO KEEP ACCOUNTS CURRENT IN ORDER TO PREVENT DISCONNECTION OF SERVICE.

For Office Use: (date and initial upon completion)

Scanned _____ CMI _____ WO _____
Laserfiche _____