



MEDICAL CERTIFICATE

Illinois Administrative Code Part 280.130 states that:

1. The illness must be certified by a registered physician or the local board of health.
2. Certification shall include:
 - a. Name, Business Address, and Telephone Number of certifying party.
 - b. A statement that termination of gas service will aggravate the illness.
 - c. Name of ill person.
 - d. A statement that he/she is a resident of the premise in question.

NICOR GAS ACCOUNT: _____

PHONE NUMBER: _____

PATIENT'S FULL NAME _____

PATIENT'S DATE OF BIRTH _____

PARENT/ACCOUNT HOLDER'S NAME _____

(_____) _____
PARENT/ACCOUNT HOLDER'S PHONE #

STREET ADDRESS _____

CITY _____

Provide a statement below explaining that termination of natural gas will aggravate the current medical condition and that the patient is a resident of the above address. Please include length of time.

Certifying Party:

Certification Date: _____

- ☐ Registered Physician
☐ Local Board of Health

Name

(_____) _____
Phone

Facility's Street Address & City

(_____) _____
Fax#

Signature

License #

All information is required, please complete the form in its entirety and fax to: (630) 428-4510.