



LIFE-SUPPORT CLASSIFICATION
APPLICATION

*(Please fill this form out and bring it to the office at:
441 West Main Street, Morristown, TN 37814)*

Account Number: _____

Name: _____

Address: _____

Phone Number: _____

Life Support Patient's Name: _____

Physician's Name: _____

Physician's Phone Number: _____

Or

Healthcare Provider's Name: _____

Healthcare Provider's Phone Number: _____

NOTORIZED documentation received on _____, _____, 20____

I hereby declare the above information to be correct and current. In addition, I acknowledge receipt of the Life-Support Policy of Morristown Utility Commission and understand the provisions therein.

Signed _____

Date _____