Physician's Certification Form
Medical Rate Assistance Program

Municipal Services
City of Santa Clara
1500 Warburton Avenue
Santa Clara, CA 95050

(408) 615-2300, Municipal Services Division
Monday - Friday, 8:00 a.m. - 5:00 p.m.
1-800-735-2922 CA Relay Service for the Deaf or Hearing Impaired

I Certify That:

Name of Patient: ____
(First, Middle, Last)

Patient's Santa Clara Address:____
(Street, City, Zip Code)

This certification will be used to evaluate the patient's eligibility for participation in the City of Santa Clara's Medical Rate Assistance Program. Applicants who are prescribed a high usage electric device by a physician for treatment of a medical condition or disability must provide a physician's certification form documenting the patient's needs and requirements for an electric device for treatment. Paraplegic, hemiplegic, or quadriplegic people qualify. Similarly, a scleroderma patient with special heating or cooling needs qualifies, as do residents depending on life support equipment.

Please list the patient's medical condition(s) that requires a high usage electric device. An electric device is defined as any device prescribed by a physician that consumes above and beyond normal energy consumption. This definition includes any prescribed durable medical equipment and/or a space conditioning device. In addition, list the electric device prescribed for this patient's treatment and the duration the patient will need the device. If the patient requires multiple devices, please provide the duration of each.

Condition Requiring Electric Device	Prescribed Electric Device	Start Date	End Date (Estimated)

Doctor's Name ____
(First, Middle, Last)

Office Address ____
(Street, City, Zip Code)

CA Physician License No.______________________ Telephone No. ______________________

This information will be used the City of Santa Clara to determine eligibility for the Medical Rate Assistance Program.
I declare, under penalty of perjury, that all the information on this certification form is correct and true.

______________________________ ______________________________
Patient's Signature Date

______________________________ ______________________________
Physician's Signature Date