

# **MEDICAL PRIORITY LIST APPLICATION**

**THIS FORM MUST BE COMPLETED AND RETURNED  
ALONG WITH A LETTER FROM YOUR PHYSICIAN  
STATING WHY YOU SHOULD BE ON THE MEDICAL  
PRIORITY LIST.**

**NAME:**

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**ADDRESS:**

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**ACCOUNT NUMBER:**

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**METER NUMBER:**

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**PHONE NUMBER:**

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**\*PLEASE BRING THIS FORM AND LETTER FROM YOUR  
PHYSICIAN TO OUR OFFICE OR MAIL TO: P. O. BOX 628  
STEVENSON, AL 35772**