## **Harrison Rural Electrification**

## **Medical Equipment Form**

Name		
Address		
City/Zip		
Telephone	Map#	
Type of Life Support Equip	ment used, manufacturer's Name, and Model Nu	mber:
Please attach physician's cer	rtification. (This must be renewed every thirty da	ys.)

Mail to: HREA PO Box 4247, Clarksburg WV, 26301