MEDICAL ALERT CERTIFICATION

In administering the medical alert program, the following information is needed to establish a medical alert code for the electric service account below.

TO BE COMPLETED BY CUSTOMER – PLEASE PRINT

Account Holder Name: _____

Account Number: _____

Mailing Address: _____

City/State/Zip: _____

Service Address: _____

City/State/Zip: _____

Home Phone: _____

Cell Phone: _____

I certify that I or a member of my household is chronically ill, handicapped or on a life support system.

Customer Signature: _____ Date: _____

The medical alert program helps us handle your account with special care. If the account is subject to disconnection for nonpayment, we will attempt to notify you to see if satisfactory payment arrangements can be made. It does not prevent disconnection. We encourage you to prepare for the possibility of a power outage by making alternative arrangements, such as battery or generator backup. ***WE CANNOT GUARANTEE A CONSTANT SUPPLY OF POWER NOR PRIORITY TREATMENT DURING AN OUTAGE.***

TO BE COMPLETE BY PHYSICIAN – PLEASE PRINT

Patient Name: _____

Age/Date Of Birth: _____

Physician Name/Business Name:: _____

Physician Phone: _____

Physician Address: _____

City/State/Zip: _____

Condition and/or Handicap: _____

Please Define: _____

Expected Duration of Condition: _____

Type of Electric Equipment Required: _____

Purpose of Equipment: _____

How Often is Equipment Used? _____

Please check the situation which most accurately describes the impact of loss of electric service to this patient.

_____ Disconnection of electrical service would be extremely hazardous to the health of the patient because the equipment is used for continual life support.

_____ Disconnection of electrical service may be a health risk if service is off for more than a few hours and no alternative arrangements have been made.

_____ Disconnection of electrical service would be an inconvenience to the patient's health but does not represent a life-threatening situation.

_____ Other (Please Explain):

Physician Signature:_____ Date:_____