Roanoke Electric Cooperative

A Touchstone Energy® Partner

Electrically Operated Medical Equipment

Medical Needs Notification

This form identifies a person residing in Roanoke Electric Cooperative's territory who depends on electrically operated medical equipment as a part of his/her continuing treatment. By signing in the space provided below, the patient agrees to the following:

- this form does not guarantee uninterrupted service
- this form does not exempt a member-owner from payment of his/her electric bills or all applicable disconnect policies
- the patient is responsible for backup equipment and/or power supply in the event of power failure or disconnection
- the patient is also responsible for a planned course of action in the event of a power outage

To Be Completed by Member-Owner/Patient:

Please enter the requested information and forward to your physician.

Name		Account Number
Address	Daytime Telephone Number	Evening Telephone Number
City	State	Zip Code
Patient Name:	Patient Age:	Member-Owners Relationship to Patient:

I have read, understand, and agree to the terms of the program as stated above and hereby authorize my physician to release the following information about the above-named patient to Roanoke Electric Cooperative and to answer related questions to help in determining the patient's medical need for electricity. I certify that the patient resides at the address listed above.

Patient Signature (Parent or guardian if patient us under 18 or mentally incapacitated).	Date

To Be Completed by Physician:

Instructions: Please complete and return this form to Roanoke Electric Cooperative to the address listed above. We will then place a note on our records to reflect that there is a medical need for electricity.

Physician Name	Telephone Number (incl. area code)	Fax Number
Hospital or Medical Group Affiliation		
Office Address	City and State	Zip Code
Patient Diagnosis		
I have prescribed the following electrically powered equipment for this patient. Please list:		
In my professional opinion, I certify that disconnection of electrical service would be extremely dangerous/life threatening because the equipment is used for life support. (Please sign)		

Please include the amount of time that patient requires the equipment and any other comments necessary.

To the extent of my knowledge, the preceding information is correct.

Signature:	Date:
Current State License or Certificate Number:	