|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MEDICAL CONDITION CERTIFICATION** | | | | | | | | |
| **Customer Information** | | | | | | | | |
| (Westfield Electric Company) Customer Name | | | Daytime Phone | | Evening Phone | | | |
| Address | | | City/Town/Village | | State | | ZIP | |
| Name of Patient With Medical Emergency, Equipment, or Under Protective Services Emergency | | | | | Relationship to Customer | | | |
| Doctor's Name | | | Title/Specialty | | | | | |
| Organization | | | Fax Number | | | Phone Number | | |
| Address | | | City/Town/Village | | | State | | ZIP |
| **Customer Authorization**  I authorize my medical, social service, and/or law enforcement provider to disclose the following information to Westfield Electric Company for the purpose of evaluating the continuation or reconnection of my utility service. I understand that acts of nature, equipment failure, etc., do happen and could result in an unplanned interruption of my utility service. Ialso acknowledge that I am responsible for an emergency backup plan.  Signature Date Verbal Authorization by Customer Date | | | | | | | | |
| **Provider Information** | | | | | | | | |
| Our customer has requested that Westfield Electric Companymake every effort to provide continuous electric utility service because of a medical emergency or a protective services emergency. In order to process this request, we need some information from you as the medical, social service, or law enforcement provider. Please complete this form and return it to us by fax or mail. You must answer **ALL** seven questions below. Thank you for your time. | | | | | | | | |
| 1. Patient's Date of Birth | | 2. Is there a medical emergency or protective services emergency present in the household?  Yes No | | | | | | |
| 3. What is the specific medical emergency or protective services emergency that exists for the patient named above? | | | | | | | | |
| 4. What, if any, life-sustaining medical equipment is required or used at the patient's location? | | | | | | | | |
| 5. How would the interruption of water service at this patient's location affect the medical emergency or protective services emergency situation?**PLEASE**  **BE SPECIFIC**. | | | | | | | | |
| 6. Can the patient use the equipment at another location where water service is available?  Yes No, (If no, why? ) | | | | | | | | |
| 7. What is the expected duration of the medical emergency or protective services emergency situation? | | | | | | | | |
| **Provider**  **Certification** | I certify the information I have provided is correct.  Signature Date | | | | | | | |
| Printed Name | | | Phone Number | | | | |
| **Please return this form by fax to: 608-296-2140** OR Mail to: Westfield Electric Company PO Box 309 Westfield, WI 53964 | | | | | | | | |
|  | | | | | | | | |

2495 03/13