



Serious Medical Condition Certification

To Be Completed by the Member:																		
Member Name:		Electric Account Number:																
Member Address:		Contact Telephone Number:																
City:	State:	Zip Code:	Alternate Telephone Number															
<i>I certify that the information provided above is accurate and the patient is the customer or a family member of the customer residing at this residence.</i>																		
Member Signature:			Date:															
To Be Completed by the Patient/ Legal Guardian/ Power of Attorney:																		
Patient Name:		Patient Relationship to Customer:																
Contact Telephone Number:		Alternative Telephone Number:																
<i>I hereby authorize my physician to release the following information about the above-named patient to the utility's representatives and/or the State Corporation Commission and to answer related questions to help determine if the identified medical condition(s) meet the definition of a serious medical condition which is defined below. I certify that the patient lives at the address listed above and that all information provided is accurate.</i>																		
Patient/ Legal Guardian/ Power of Attorney Signature			Date:															
To Be Completed by the Physician (M.D. or D.O.):																		
Physician Name:		Contact Telephone Number:																
Physician Office Address:		Alternative Telephone Number:																
City:	State:	Zip Code:	Fax Number:															
Current License Number:		Licensing State:																
<u>Patient's Diagnosis/Serious Medical Condition</u>																		
<u>Required Treatment for Condition:</u>																		
<u>Equipment prescribed and/or equipment required for treatment of condition (if any): (Check all that apply):</u>																		
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Mechanical Ventilator</td> <td style="width: 33%;"><input type="checkbox"/> CPAP Machine</td> <td style="width: 33%;"><input type="checkbox"/> Ventricular Assist Device</td> </tr> <tr> <td><input type="checkbox"/> Feeding Pump</td> <td><input type="checkbox"/> Nebulizer</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Infant Apnea Monitor</td> <td><input type="checkbox"/> Hospital Bed</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Continuous Oxygen</td> <td><input type="checkbox"/> Refrigeration</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Home Dialysis</td> <td><input type="checkbox"/> HVAC</td> <td></td> </tr> </table>				<input type="checkbox"/> Mechanical Ventilator	<input type="checkbox"/> CPAP Machine	<input type="checkbox"/> Ventricular Assist Device	<input type="checkbox"/> Feeding Pump	<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Infant Apnea Monitor	<input type="checkbox"/> Hospital Bed		<input type="checkbox"/> Continuous Oxygen	<input type="checkbox"/> Refrigeration		<input type="checkbox"/> Home Dialysis	<input type="checkbox"/> HVAC	
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<u>Expected Duration of Condition:</u>																		
<i>I certify that the above patient has a serious medical condition which is defined as a physical or psychiatric condition that requires medical intervention to prevent further disability, loss of function, or death. Such conditions are characterized by a need for ongoing medical supervision or the consultation of a physician. A serious medical condition carries with it a risk to health beyond that experienced by the majority of children and adults in their day-to-day minor illnesses and injuries. Individuals with a serious medical condition may require administration of specialized treatments and may be dependent on medical technology such as ventilators, dialysis machines, enteral or parenteral nutrition support, or continuous oxygen. Medical interventions may include medications with special storage requirements, use of powered equipment, or access to water. I certify that the preceding information is correct.</i>																		
Physician's Signature:			Date:															

This form was developed pursuant to: 20VAC 5-330 "Limitations on Disconnection of Electric and Water Service"

Form SMCC (01/2017)