Sussex Rural Electric Cooperative, Inc.
A Touchstone Energy® Cooperative

Medical Alert Program Application Form

Enrolling in the **Medical Alert Program** will give you advance notice of a planned outage in order for you to have time to make alternate plans. If electricity is a medical necessity, you must make other arrangements for on-site back-up capabilities or other alternatives in the event of loss of electric service. The **Medical Alert Program** does not relinquish you from paying your account on time, nor does it make you exempt from the delinquency disconnection process.

PLEASE NOTE: Enrolling in the Medical Alert Program does not guarantee an uninterrupted, regular, or continuous power supply nor does it restore your power any faster during an unplanned outage.

1. MEMBER INFORMATION

Member Name: _____ Account Number:_____

Address: _____

Email: _____Phone: _____

2. DOES THE PATIENT LISTED ABOVE REQUIRE LIFE-SUSTAINING EQUIPMENT IN THEIR HOME?* **Yes** ☐ **No** ☐

*If Yes, complete sections 2, 4, and 5. If no, complete sections 3 and 4.

Equipment Type: _____ Is there an alternate power supply available? Yes ☐ No ☐

3. OTHER MEDICAL CONDITIONS Complete this section if you have a serious medical condition that does not require life-sustaining equipment, but you would be affected if there was a loss of power or shut-off of electric service and you wish to have advanced notification of planned outages.

Equipment Type: _____ Is there an alternate power supply available? Yes ☐ No ☐

4. Certification

I certify the information in this application is true. I understand the Medical Alert Program does not guarantee uninterrupted, regular, or continuous power supply. It will not restore my power any faster during an unplanned outage. It will only give me advance notice of a planned outage in order to have time to make alternate plans. In the event of a natural emergency I agree that SREC can release my medical alert information to authorized town or county office of emergency management personnel. If electricity is a medical necessity, I understand I must make other arrangements for on-site back-up capabilities or other alternatives in the event of loss of electric service and I understand that the Medical Alert Program does not relinquish me from paying, nor does it make me exempt from the delinquency disconnection process.

Member Signature:_____ Date:_____

5. PHYSICIAN'S CERTIFICATION (REQUIRED FROM PRESCRIBING MEDICAL PROFESSIONAL)

Medical Professional's Name: _____Practice and/or Specialty: _____

Office Address: _____Office Phone: _____

I certify that the patient listed above uses life-sustaining equipment that requires electricity in their home prescribed by me.

Prescribing Medical Professional Signature _____ Date: _____