# Central Florida Electric Cooperative, Inc.

P.O. Box 9, Chiefland, FL 32644

# Medically Essential Service

In order for Central Florida Electric Cooperative, Inc. to determine whether a customer is eligible for designation as a Medically Essential Service Customer, Part A must be completed by the customer and Part B by the patient's physician and the entire form returned directly to Central Florida Electric Cooperative, Inc., P.O. Box 9, Chiefland, Florida 32644.

Part A: CUSTOMER APPLICATION

Date: _____ Customer # _____

Customer Name: _____ SSN _____

Service Address: _____

Daytime Phone: _____ and/or _____

Name of Person Using Equipment: _____

User's Physician _____

Central Florida Electric Cooperative, Inc. has fully explained how my account will be handled regarding any collection action due to non-payment of the bill. I understand that Central Florida Electric Cooperative, Inc. not guarantee uninterrupted service or assign a priority status to my account for service restoration during outages. I understand that I must be prepared with backup equipment and/or power and a planned course of action in the event of a power outage. I agree to notify Central Florida Electric Cooperative, Inc. when this equipment is no longer in use.

Customer Signature: _____ Date: _____

Part B: PHYSICIAN'S CERTIFICATE

Physician's Name: _____

Physician's License #: _____

Physician's Address: _____

Phone Numbers: _____ and/or _____

User's Physician _____

I,_____ (Name of Physician), duly licensed and authorized to practice medicine In the State of Florida, hereby certify that_____ (Name of Patient), who resides at_____ (patient's place of residence) and who is under my care, relies upon continuously operating electric powered medical equipment In order to sustain his/her life or to avoid serious medical complications requiring his/her immediate hospitalization. The continuously operating medical equipment upon which this patient relies is described as follows:

_____

_____

_____

The patient uses this equipment _____ hours within each twenty-four (24) hour period. Following is the reason(s), in my opinion, this patient needs the continuous use of this equipment in order to sustain his/her life or to avoid serious medical complications requiring his/her immediate hospitalization: (Attach additional pages if necessary)

Physician's Signature: _____ Date: _____

This certificate shall be deemed valid for a period of twenty-four (24) months from the date the certificate Is accepted by Central Florida Electric Cooperative, Inc. for purposes of determining that a customer qualifies as a Medically Essential Service Customer as defined by Central Florida Electric Cooperative, Inc. policies and procedures, or that such designation should by renewed.

 Updated August 2017