MEDICAL CONDITION CERTIFICATION

Customer Information

Marshfield Utilities Customer Account holder NAME	Phone (circle one) cell/land line	Email address	
Address	City/Town/Village	State	ZIP
Name of Patient with Medical Emergency, Equipment or under Protective Service Emergency		Relation 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 Marshfield Utilities for the purpose of evaluating the continuation or reconnection of my electrical service. I understand that acts of nature, equipment failure, etc. do happen and could result in an unplanned interruption of my utility service. I also acknowledge that I am responsible for an emergency backup plan.

Customer Signature ______________________________ Date ____________________

Customer Verbal Authorization ______________________________ Date ____________________

Provider Information

Our Customer requested that Marshfield Utilities make every effort to provide continuous electric utility service because of a medical emergency or a protective service 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 email. Please do not leave any question unanswered. *Thank you for your assistance.*

'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 electric utility 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 electric 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:__________

Provider Printed Name	Phone Number
Provider Organization	Provider Address

Return to Marshfield Utilities at:

By Fax: **715-389-2016**

By email: **CustomerAccounts@MarshfieldUtilities.org**

Marshfield Utilities Customer Accounts Office Use ONLY	Date Received:
	Account #
	Action Taken
	Scanned?