Medical Certification
Marshall-DeKalb Electric Cooperative

Instructions:

The following is to be completed by a licensed medical professional, and only after you or someone in your office has examined the individual whose name appears as the patient on the form below. This form applies only in situations where, in your professional opinion, termination of electrical utility service would be especially dangerous to the health of that individual. If, in your professional opinion, an especially dangerous situation does not exist, please do not sign this form.

If you have any questions regarding this form, please contact Marshall-DeKalb Electric Cooperative at 1800-239-3692. You may fax the completed form to us at 256-840-2211.

**I certify that, to the best of my knowledge, the information provided below is true.**

The following medical information must be certified by one of the following. Please indicate if you are a:

□ licensed physician □ physician assistant
□ clinical nurse specialist □ certified nurse practitioner
□ certified nurse-midwife □ local board of health physician

Please complete the following. Please print.

I certify that my patient has been examined by me and I have determined the following to be true: Name of patient: _____
Patient's permanent residence: (street address)_____
(city, state, zip code)_____
Phone Number_____
Marshall-DeKalb Electric Cooperative Location #: _____

Check the box of the applicable condition:
□ This patient suffers from a hazardous medical condition and termination of electrical utility service would be especially dangerous or life- threatening.
□ This patient uses medical or life-supporting equipment and termination of electrical utility service would make operation of that equipment impossible or impractical.

I certify that I advised my patient that disclosure of the requested information may be subject to redisclosure by the recipient and no longer protected by the HIPAA rules and regulations.

Authorized Signature_____
Date _____
(Please Print) Name of Licensed Medical Professional_____
Business Address _____
Business Telephone_____
Current State License or Certificate Number: _____
All sections must be fully completed in order to process the medical certification request.

This Certification does not in any way remove the obligation to pay for services received or to be received by Marshall-DeKalb Electric Cooperative.