



"Neighbors Working for Neighbors"

A Touchstone Energy® Cooperative 

# MEDICALLY ESSENTIAL SERVICE CERTIFICATION FORM

## Part B: PHYSICIAN'S CERTIFICATE

PLEASE TYPE OR PRINT CLEARLY

Physician's Name: \_\_\_\_\_

Physician's License No.: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Phone Numbers: ( ) \_\_\_\_\_ and/or ( ) \_\_\_\_\_

I, \_\_\_\_\_ (Name of Physician), duly licensed and authorized to practice medicine in the State of Florida , hereby certify that \_\_\_\_\_ (Patient's Name), who resides at \_\_\_\_\_ (Patient's place of residence) and who is under my care , relies upon continuously operating electric-powered medical equipment described as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The patient uses this equipment \_\_\_\_ hours within each twenty-four 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 twelve (12) months from the date the certificate is accepted by GEC for purpose of determining that a member qualifies as a Medically Essential Service Customer as defined by GEC's policies and procedures, or that such designation should be renewed.