

# Medically Essential Service Certification

In order for Glades Electric Cooperative to determine whether a member is eligible for the designation as a Medically Essential Service Member, Part A must be completed by the member and Part B by the patient's physician. Return the completed form to the Member Service Department at Glades Electric Cooperative.

## Part A: Member Application

*Please type or print clearly*

Date: \_\_\_\_\_  
Account Number: \_\_\_\_\_ Location Number: \_\_\_\_\_  
Member Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Service Address: \_\_\_\_\_

Patient's Name (if not member) using equipment: \_\_\_\_\_  
(patient must be a resident of member's home)

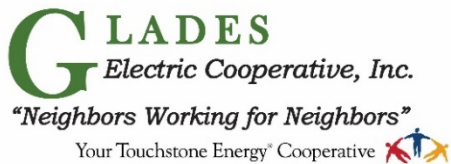
Does the patient have auxiliary power: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, is it battery or generator power? \_\_\_\_\_  
Name & Type of equipment: \_\_\_\_\_  
Physician's Name: \_\_\_\_\_  
Physician's Address: \_\_\_\_\_

GEC has fully explained how my account will be handled regarding any collection action due to non-payment of the bill. I understand that GEC does 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 power outages. I agree to notify GEC when this equipment is no longer in use.  
PLEASE NOTE: GEC may share this information with the Emergency Management/Disaster Preparedness Organization in my City or County.

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Entered by GEC Employee: \_\_\_\_\_ Date: \_\_\_\_\_  
Notes: \_\_\_\_\_

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



# Medically Essential Service Certification

## Part B: Physician's Certificate

*Please type or print clearly*

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

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

Physician's Phone Number(s): \_\_\_\_\_

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 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.