

# Northeast Oklahoma Electric Cooperative

## Medical Certificate Form

Fax: **918-256-9304** or Mail to: **PO Box 948 Vinita OK 74301-0948** Phone: **800-256-6405**

The Oklahoma Corporation Commission requires electric and gas utilities under its jurisdiction to honor certificates which attest to the fact that a utility consumer or a permanent member of the household has a medical condition such that discontinuance of service will give rise to a substantial risk of death or a grave impairment of the health of the utility consumer or other permanent resident of the premises where services are rendered. The respective consumer may initially certify the condition, but further verification of the condition is required if it persists beyond a 30-day period. **Verification must be by medical personnel licensed by the state; these include Medical Doctors, Doctors of Osteopathy and County Medical Directors. As per the Oklahoma Corporation, any form signed by someone other than the above noted medical professionals, such as a nurse practitioner or physician's assistant, will not be accepted.** You are being asked to provide verification that the stated condition still exists and will continue to exist for a specified period of time.

Please be advised that your actions in this matter may result in this person being permitted to use utility services without immediate payment if their financial condition so warrants. However, full restitution is required when the "life-threatening" condition ceases to exist within a certain timeframe.

We appreciate your willingness to participate as a verifier and trust you will do so advisedly, considering the fact that energy consumed during this period must eventually be paid for by the utility consumer.

We want to assure that those utility consumers having a genuine life-threatening condition in their homes are not mistaken for those who would abuse this privilege at the expense of other ratepayers.

### MEMBER INFORMATION (Please print)

Name of Member: \_\_\_\_\_ Electric Account Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Name of Impaired Household Resident: \_\_\_\_\_ Relationship to Member: \_\_\_\_\_

**Please notify the REC office when person with medical condition moves or is deceased**

### Health Condition Verification

*(Completed by Licensed Medical Personnel)*

A Cooperative Representative will contact the agency to verify the below information.

Name of Patient: \_\_\_\_\_

Nature of medical condition that warrants this form: \_\_\_\_\_

\_\_\_\_\_

Is this condition considered life threatening without electric service? Yes No

What is the estimated duration of the life-threatening condition? \_\_\_\_\_

Specify the effect discontinuance of electric service would have on the impaired individual:

\_\_\_\_\_

List any electrical equipment being used at the residence that is necessary for life support:

\_\_\_\_\_

Name: \_\_\_\_\_ Agency: \_\_\_\_\_

Title or Occupation: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_