



Verification of Medical Condition

This form expires 2 years from date of receipt.

Return by Fax: 715-273-4476 or Mail: PO Box 420, Ellsworth, WI 54011.

Please note: All information must be completed or will not be accepted. Being on PPCS' medical condition list does not guarantee that your electric service will receive priority for restoration of service. This allows PPCS to attempt to inform members of planned outages so other arrangements can be made. This also does not exempt from financial responsibilities or from termination of service in accordance with established PPCS policies.

Section 1-Member Information

Member Name: _____ Date of Birth: _____

Account Number: _____ Phone Number: _____

Service Address: _____

Section 2-Patient Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient is: the Member Spouse of the Member Parent of the Member

Child of the Member Other (specify) _____

I authorize my physician to release information regarding my medical condition to Pierce Pepin Cooperative Services. In the case of a minor or incapable person, I, as the guardian or representative, authorize the same disclosure of records about the person I represent.

Patient's Signature: _____ Date: _____

Section 3-Completion by Licensed Physician

Physician Name: _____

Physician Address: _____

Physician Phone Number: _____

Medical Equipment Information

Is this a **critical illness** requiring **life support**? Yes No

Please identify and describe the patient's medical condition:

Please explain why electricity is necessary for this condition:

Please turn over to complete form.

(Cont'd) Section 3-Completion by Licensed Physician

Is electricity required to operate medical equipment which provides life support? Yes No

If yes, what type of **life support** equipment is needed?

How often is this **life support** equipment used?

Does the medical equipment have battery backup that allows it to operate in the event of a storm or other unscheduled power interruption? Yes No

If yes, please explain how this situation is different.

Can the medical equipment in use be portable to where it could be used at a location other than the patient's primary residence? Yes No

If yes, please explain why a declaration of emergency is necessitated for the primary residence.

I acknowledge that I am willfully declaring a protective services emergency, and attest that the information filled out on this form is complete and true to the best of my knowledge.

Physician's Signature: _____ Date: _____

Revised: August 2024