Lorain-Medina Rural Electric Cooperative, Inc.

PO Box 158
Wellington, Ohio
44090

Telephone: (440) 647-2133
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Medical Certification Form

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 electric 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.

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) _____

☐ This patient suffers from a hazardous medical condition and termination of electric utility service would be especially dangerous or life-threatening.

☐ This patient uses medical or life-supporting equipment and termination of electric utility service would make operation of that equipment impossible or impractical.

☐ This patient is temporarily residing at the following address during treatment or recovery.
Patient's temporary residence: (street address) _____

(city, state, zip code) _____

I certify that I advised my patient that disclosure of the requested information may be subject to redisclosure by the recipient and no longer be protected by the HIPPA rules and regulations. All signed statements are effective for one year from date of signature.

_____ _____

Licensed Medical Professional Signature Date of Signature

_____ _____

Name of Licensed Medical Professional Current State License Number

Business Address and Phone Number (required):

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All sections must be fully completed in order to process the medical certification request.