REDWOOD ELECTRIC COOPERATIVE
LIFE-SUSTAINING MEDICALLY NECESSARY EQUIPMENT FORM

MEMBER CERTIFICATION: (To be completed by member)

Member Name: ____ Account # ____________________________________

Member Address: ____

City, State, Zip: ____

Home Phone: ___________________________________ Cell Phone: ____

Resident(s) requiring life-sustaining medically necessary equipment:

____

Relationship to Member: ____

RELEASE: (to be completed by Resident requiring life-sustaining equipment or his/her legal guardian)

I _______________________________ (circle one: resident or legal guardian) hereby grant my consent to the below-named licensed physician to release to Redwood Electric Cooperative, the information below.

Signature of Resident or Leal Guardian: ____ Date: _________________________

MEDICAL CERTIFICATION: (To be completed and signed by a licensed medical provider)

I certify that the termination of electricity would disrupt the use of LIFE-SUSTAINING MEDICALLY NECESSARY EQUIPMENT and would create a medical emergency for

____

Who is a permanent resident at: ____

____

Physician Name: ____ Phone: ______________________________
(Please Print)

Address: ____

City: ____ State: ___________________________ Zip: _______________________

Signature: ____ Date: ___________________________

Please fax or mail completed form to:

REDWOOD ELECTRIC COOPERATIVE
60 PINE ST. CLEMENTS, MN 56224
FAX: 507-692-2211