Union Power Cooperative
A Touchstone Energy® Cooperative

MEDICAL NEED FOR ELECTRICITY

IMPORTANT NOTE: Completion of this form in no way ensures uninterrupted service, nor does it guarantee priority restoration of your service. Union Power Cooperative (UPC) *strongly recommends* members with medical needs have an alternate plan for electric service in the event of an outage.

In order for your medical need to be documented by UPC, you are required to submit the completed form below, with the physician signature for certification.

Mail to: Customer Service, Union Power Cooperative, Attn: Medical Need, PO Box 5014, Monroe, NC 28111 or fax to 704-296-0408. Questions may be directed to Customer Service at 704-289-3145 or 800-922-6840, ext. 3804.

To Be Completed by the Member:			**AN UPDATED FORM MUST BE SUBMITTED ANNUALLY TO UPC**
Member Name:			Electric Account Number:
Member Address:			Phone Number:
City:	ST:	Zip:	Alternate Phone Number:

I certify that the information above is accurate and the patient is the Union Power Cooperative member or a family member of the Union Power Cooperative member residing at this residence.

Member Signature: _____ Date: _____

To Be Completed by the Patient/Legal Guardian/Power of Attorney:	
Patient Name:	Patient Relationship to Member:
Contact Telephone Number:	Alternate Phone Number:

I hereby authorize my physician to release the following information about the above-named patient to the utility's representatives and to answer related questions to help determine if the identified medical condition(s) meets the definition of a serious medical condition which is defined below. I certify that the patient lives at the address listed above and that all information provided is accurate.

Patient/Legal Guardian/Power of Attorney Signature: _____ Date: _____

To be Completed by the Physician (M.D. or D.O): (REQUIRED)			
Physician Name:			Phone Number:
Physician Street Address:			Alternate Phone Number:
City:	ST:	Zip:	Fax Number:
Patient's Diagnosis/Serious Medical Condition & Equipment Prescribed, if any:			

I certify that the above patient has a serious medical condition which is defined as a physical or psychiatric condition that requires medical intervention to prevent further disability, loss of function, or death. Such conditions are characterized by a need for ongoing medical supervision or the consultation of a physician. A serious medical condition carries with it a risk to health beyond that experienced by the majority of children and adults in their day-to-day minor illnesses and injuries. Individuals with a serious medical condition may require administration of specialized treatments and may be dependent on medical technology such as ventilators, dialysis machines, enteral or parenteral nutrition support or continuous oxygen.

_____ _____

Physician's Signature **REQUIRED** Date