Northeast Oklahoma Electric Cooperative, Inc.

MEDICAL CERTIFICATE FORM

FAX: 918-256-9304 or MAIL FORM 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 health. **Verification must be made by medical personnel licensed by the state; these include Medical Doctors, Doctors of Osteopathy, and County Medical Directors**. ***As per the Oklahoma Corporation Commission, 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. The suspension of disconnection will allow the member to pay the account in full or enter into a payment arrangement to then pay the account in full. 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: _____

I do hereby acknowledge that a permanent resident of the household is applying for the life-threatening situation certificate and further acknowledge the responsibility for payment of bills rendered for electric service.

Electric Account Holder (Member) Signature: _____

Please notify this 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 information below

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:

_____

Printed name of Physician: _____ Agency: _____

Title of Physician: _____ Phone number: _____

Address: _____City: _____State _____Zip: _____

Signature: _____ Date: _____