People's Energy Cooperative

Your Touchstone Energy® Cooperative

Medical Alert Priority List

Date_____

(Note: This form is to be completed annually by the member's physician.)

Member Name: _____

Address: _____

_____

Phone: _____

Email: _____

Please place _____and/or family on your Medical Alert Priority List for restoration of service if a power failure should occur.

This patient is currently under my care for a life threatening condition. They are using the following life monitoring and/or support equipment:

_____

_____

The equipment in use is electrically powered and may or may not have battery support.

Duration of Need: (Please choose one.)

- ☐ Permanent (Until further notice. Note: If longer than 12 months, then a new form will need to be submitted annually.)
- ☐ Temporary (Until _____ Month/Day/Year)

Your cooperation in helping this patient and family maintain electrical service will be greatly appreciated.

Sincerely,

Physician's Signature _____

Physician's Printed Name _____

Physician's Business Address _____

_____

Physician's Telephone Number _____