MEDICAL CONDITION CERTIFICATION FORM

In accordance with the requirements of Ohio Law relating to electric service, we request that a licensed physician please complete and certify the following information. If initial certification was by phone, this form must be signed by the physician and returned or faxed immediately. Return to:

BUCKEYE RURAL ELECTRIC COOPERATIVE, INC.
4848 State Route 325 South
PO Box 200
Rio Grande, Ohio 45674-0200 FAX (740) 379-2048

I hereby certify that _____, a permanent resident
(Full name of patient)
of _____

_____, _____, _____.
City State Zip

Check appropriate box

- ❑ Dependent upon a necessary medical or life-support system, apparatus or machine in his/her place of residence;
- ❑ Suffering or recovering from a serious illness, sickness or injury;
- ❑ Other (explain)
- ❑ The nature of the illness or injury which requires medical or life-support equipment or confinement to the home is:

_____

_____

This condition is expected to last for the following period: _____

_____
(Expected duration of patient's condition)

Termination of electrical service during this period would be especially dangerous to the above patient's health or make the operation of necessary medical or life-support equipment impossible or impractical.

Date: _____ _____
Licensed Physician Signature

_____ _____
Phone Address