Suwannee Valley Electric Cooperative

Medical Necessity Form

Account Information:

Account #:_____

Name on Account: _____

Service Location Address: _____

Home Phone: _____

Mobile Phone: _____

Name of Person Using Equipment: _____

Medical Equipment:

Type of Equipment in Use: _____

Is this equipment necessary to sustain life: □ Yes □ No

Physician's Certification:

Physician's Name (please print):_____

Address: _____

Phone Number: _____

As the above patient's physician, I certify that the above listed equipment is necessary to sustain life for my patient.

Physician's Signature_____ Date: _____

The information collected above will be used in the event of prearranged power outages and disconnects. This form does not guarantee a higher level of service or guaranteed service should the area experience a power outage.

This form is for information purposes only and is valid for five years. An updated form is required every five years.

SVEC Internal Use Only

Date Received: _____ By: _____