Headquarters Office
P. O. Box 2451
11633 Hwy 92 West
Chase City, VA 23924
Phone: 434-372-6100
Fax: 434-372-6241

www.meckelec.org

MECKLENBURG ELECTRIC COOPERATIVE
Your Touchstone Energy® Partner

Chase City District
434-372-6200

Emporia District
434-634-6168

Gretna District
434-656-1288

NOTIFICATION OF ELECTRICALLY OPERATED EQUIPMENT FOR MEDICAL NEEDS

The purpose of this form is to identify Cooperative members who require electrically operated equipment to meet their medical needs. It is our goal to provide the highest quality service by maintaining an up-to-date medical equipment record; therefore, this form must be updated and returned by February 1 of each year.

TO BE COMPLETED BY COOPERATIVE MEMBER *Instructions: Please provide the requested information and then forward this form to your Doctor.*		
Name of Member (As it appears on the bill):		
Address (911 address that receives electric service):		
City:	State:	Zip Code:
Daytime Phone #: ( )	Evening Phone #: ( )	
Mecklenburg Electric Account Number:		
Name of Patient residing at account:	Patient's Age:	
Member's Relationship to Patient: □ Self □ Spouse □ Parent □ Guardian □ Other(Specify)		

I hereby authorize my physician to release the following information about the above named patient to Mecklenburg Electric Cooperative and to answer related questions to help in determining the patient's medical need for electricity. I certify that the patient resides at the above listed address.

Patient Signature (Parent or guardian, if patient is under 18 or mentally incapacitated)

_____ Date: _____

TO BE COMPLETED BY THE PHYSICIAN *Instructions: Please complete and fax this form within 10 working days to Mecklenburg Electric Cooperative at the fax number listed above. We will then note in our member records the patient's need for electrically operated medical equipment.*	
Physician's Name:	Physician's Phone #: ( )

I have prescribed the following electrically powered medical equipment for this patient. (Please check as applicable)

❑ Mechanical Ventilator ❑ Home Dialysis Machine ❑ IV Pump ❑ Continuous Oxygen

❑ Other (Specify):_____

To the extent of my knowledge, the preceding information is correct.

Physician Signature: _____ Date: _____