



## MEDICAL ALERT CERTIFICATION

Name on Customer Account: \_\_\_\_\_

Customer/Location Number: \_\_\_\_\_

Service Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Emergency Number: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Medical Condition: \_\_\_\_\_

Type of Life Support System: \_\_\_\_\_

The customer agrees that it is their responsibility to provide the letter of certification from a doctor or hospital advising of their medical condition. The certification will be reviewed and brought up to date each year.

By signing this agreement, **the customer agrees to pay his/her account by the due date**, so that service will not be interrupted for failure to pay. Wilson Energy will make every effort to make contact with the customer before service is terminated.

Wilson Energy will exercise due diligence in delivering power to life support patients. However, due to conditions beyond the control of Wilson Energy, electric power cannot be guaranteed 100 percent of the time. **It is understood that the customer should have a back-up plan for movement of the patient if Wilson Energy is unable to restore power.**

Signature of Customer \_\_\_\_\_ Date \_\_\_\_\_

### Physician Information:

The above information is true concerning the above referenced patient's medical condition:

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

### FOR OFFICE USE ONLY:

Representative Signature \_\_\_\_\_ Date \_\_\_\_\_