Certification of Medical Emergency

* The below information is REQUIRED to establish a medical protection status for your utility services.
* This form must be filled out completely and stamped by a medical professional.
* If the medical protection is no longer required, please complete Steps 1 and 4.

Account Number:

Name of Account Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account Holder Primary Contact Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Secondary Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **STEP 1 of 4 – Patient Information – Complete and return via fax, email or mail within 30 days of receipt. Please print/type clearly.** | | | | | |
| **FAX:**  [(718) 246-311](mailto:lifesupportequipment@coned.com)5  **EMAIL**  [LifeSupportEquipment@coned.com](mailto:LifeSupportEquipment@coned.com) | **Mailing Address**  Con Edison  Cooper Station  P. O. Box 138 New York, NY 10276-0138 | | | | |
| Patient’s Name: | | | | | Date of Birth (for medical verification): |
| Street Address: | | | | | City, State, Zip Code: |
| Patient Primary Telephone Number:  ( ) - | | Patient Alternate Telephone Number:  ( ) - | | | |
| Emergency Contact Name: | | Emergency Contact Telephone Number:  ( ) - | | | |
| **STEP 2 of 4 - Medical Information –** Must be completed by a Licensed Medical Professional | | | | | |
| Nature of Serious Illness or Medical Condition: | | | Medical Equipment Needed: | | |
| Please describe how the illness or medical condition will be aggravated by the absence of utility service (REQUIRED): | | | | | |
| **STEP 3 of 4** - Must be completed and stamped by a Licensed Medical Professional – **ALL FIELDS REQUIRED** | | | | | |
| I verify that the patient/account holder named above requires medical protection and resides at the above address. | | | | | |
| Medical Professional Name: | | | | License #: | Medical Stamp: |
| Medical Facility: | | | | Facility Phone Number: |
| Street Address: | | | | City, State, Zip Code: |
| Medical Professional Signature: | | | | Date: |
| **STEP 4 of 4 - LIFE SUPPORT REMOVALS ONLY -** Please mark checkbox, sign, and date for **REMOVALS ONLY** | | | | | |
| The patient/account holder named above no longer requires the use of Life Support Equipment. | | | | | |
| **Signature (REQUIRED):** | | | | | **Date:** |