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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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) 246-3115**EMAIL** LifeSupportEquipment@coned.com | **Mailing Address**Con EdisonCooper StationP. 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:** |