Certification of Medical Emergency

conEdison

The below information is REQUIRED to establish a medical protection status for your utility services.

Account Number: _____

Name of Account Holder: _____

Account Holder Primary Contact Number:
( ) - - _____

Secondary Number:
( ) - - _____

Complete and return via fax, email or mail within 30 days of receipt. Please print/type clearly. 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.

Fax: (718) 246-3115

Email: LifeSupportEquipment@coned.com

Mailing Address: Con Edison
Cooper Station
P. O. Box 138 New York, NY 10276-0138

STEP 1 OF 4: PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

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 Facility: _____ Facility Phone Number: ( ) - - _____

Street Address: _____ City, State, Zip Code: _____

Medical Professional Signature: _____ Date: _____

Medical Stamp:

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: _____