MEDICAL CONDITION CERTIFICATION

Customer Information

(Pioneer Power and Light Company) Customer Name	Daytime Phone	Evening Phone	
Address	City/Town/Village	State	ZIP
Name of Patient With Medical Emergency, Equipment, or Under Protective Services Emergency		Relationship to Customer	
Doctor's Name	Title/Specialty		
Organization	Fax Number	Phone Number	
Address	City/Town/Village	State	ZIP

Customer Authorization

I authorize my medical, social service, and/or law enforcement provider to disclose the following information to Westfield Electric Company for the purpose of evaluating the continuation or reconnection of my utility service. I understand that acts of nature, equipment failure, etc., do happen and could result in an unplanned interruption of my utility service. I also acknowledge that I am responsible for an emergency backup plan.

Signature _____ Date _____

☐ Verbal Authorization by Customer Date _____

Provider Information

Our customer has requested that Westfield Electric Company make every effort to provide continuous water utility service because of a medical emergency or a protective services emergency. In order to process this request, we need some information from you as the medical, social service, or law enforcement provider. Please complete this form and return it to us by fax or mail. You must answer **ALL** seven questions below. Thank you for your time.

1. Patient's Date of Birth

2. Is there a medical emergency or protective services emergency present in the household?
☐Yes ☐No

3. What is the specific medical emergency or protective services emergency that exists for the patient named above?

4. What, if any, life-sustaining medical equipment is required or used at the patient's location?

5. How would the interruption of water service at this patient's location affect the medical emergency or protective services emergency situation? **PLEASE BE SPECIFIC**.

6. Can the patient use the equipment at another location where water service is available?
☐Yes ☐No, (If no, why?_____)

7. What is the expected duration of the medical emergency or protective services emergency situation?

Provider Certification

I certify the information I have provided is correct.

Signature _____ Date _____

Printed Name	Phone Number

Please return this form by fax to: 608-296-2140 OR Mail to: Pioneer Power and Light Company PO Box 309 Westfield, WI 53964