To be completed annually, or as medical conditions warrant.

Rio Grande Electric Cooperative
Critical Care Medical Form

Electric Account Number: ___________________________ Meter #: ___________________________

Name of Account Holder: ___________________________

Name of Critical Care Person: _________________________

Relationship to Account Holder:  ❑ Self   ❑ Spouse   ❑ Parent   ❑ Child   ❑ Renter

❑ Other, please specify _____________________________

Contact Information: Please include both day and evening numbers.

Telephone number(s) of Account Holder: ___________________________

Telephone number(s) of Critical Care Person or live-in caregiver, if different than Account Holder:

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To be completed by physician – Please type

Description of patient’s medical condition: _____________________________________________________________

Critical medical equipment at the residence requiring electric power for operation: ___________________________

Name of Physician: ___________________________

Name of Medical Facility at which Physician Practices: __________________________________________________

Physician’s mailing address: ___________________________

Physician’s Phone Number: ___________________________

Note To Physician: With regard to planned power outages, Rio Grande Electric Cooperative (RGEC) will attempt to contact your patient requiring electrically-powered medical equipment in advance so that they can make arrangements for transport to another location, if necessary. However, because of the wide variety of circumstances under which (unplanned) power outages occur, RGEC cannot guarantee restoration time. If your patient has critically important medical equipment that requires electric power for operation, they should have a back-up source of power available at their residence.

_________________________________________ Signature of Licensed Medical Doctor ___________________________

Date Signed

This form is also available under the Forms tab at www.riogrande.coop