



**SOUTHSIDE ELECTRIC
COOPERATIVE, INC.
P.O. BOX 7
CREWE VA 23930-0007**

Your Touchstone Energy® Cooperative 

**PHONE: 1-800-552-2118
Email: kyle.rainwater@sec.coop
www.sec.coop**

"Serious Medical Condition Certification Form"

Dear Member:

We have been informed that you have a serious medical condition which requires (1) ongoing medical supervision, (2) consultation of a physician, (3) administration of specialized treatments, (4) dependence on medical technology, e.g. ventilators, dialysis machines, enteral or parenteral nutrition support or continuous oxygen, (5) medications with special storage requirements and (6) the use of powered equipment or access to water.

Please complete the enclosed "Serious Medical Condition Certification Form," or have your Legal Guardian or Power of Attorney fill out the Form and return it to the Cooperative. Please notice that there is a section that must, also, be completed and signed by a licensed physician that, essentially, certifies that the medical condition meets the definition of a serious medical condition identifies, both, the anticipated length of time the serious medical condition will persist, as well as any equipment prescribed or treatment required for medical condition.

As soon as the "Serious Medical Condition Certification Form" has been received, your account will be pinpointed and identified on the Cooperative's mapping system which, in turn, will help us notify you in cases of planned power outages. Priority is, also, given to these account locations in the event of extended power outages. Southside Electric Cooperative cannot guarantee you that the electricity at your account location will not be interrupted, nor can it assure you that the power outage will only be for a short period of time. It is, therefore, important that "Serious Medical Condition Certification Form" is completely filled out and that you are familiar with the type of medical equipment you are using, e.g. backup features and/or what assistance(s) are available from your health care provider during an extended power outage.

There are various types of small portable, standby generators that can be purchased and used by you in the event of extended power outages. Cooperative personnel are available to advise you in the selection, installation and use of standby generation equipment.

Again, please complete the enclosed "Serious Medical Condition Certification Form" and return it to the Cooperative at your earliest Convenience.

Cordially,

Kyle Rainwater

Kyle Rainwater

Enclosure



P.O. BOX 7
 CREWE, VIRGINIA 23930-00007
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 Email: kyle.rainwater@sec.coop
 www.sec.coop

Serious Medical Condition Certification Form

Form SMCC (01/2017)

To Be Completed by the Customer:			
Customer Name:		Electric Account Number:	
Customer Address:		Water Account Number:	
		Contact Telephone Number:	
City:	State:	Zip Code:	Alternate Telephone Number:
<i>I certify that the information above is accurate and the patient is the customer or a family member of the customer residing at this residence.</i>			
Customer Signature:		Date:	
To Be Completed by the Patient/Legal Guardian/Power of Attorney:			
Patient Name:		Patient Relationship to Customer:	
Contact Telephone Number:		Alternate Telephone Number:	
<i>I hereby authorize my physician to release the following information about the above-named patient to the utility's representatives and/or the State Corporation Commission and to answer related questions to help determine if the identified medical condition(s) meets the definition of a serious medical condition which is defined below. I certify that the patient lives at the address listed above and that all information provided is accurate.</i>			
Patient/Legal Guardian/Power of Attorney Signature:		Date:	
To be Completed by the Physician: (M.D. or D.O)			
Physician Name:		Contact Telephone Number:	
Physician Office Address:		Alternate Telephone Number:	
City:	State:	Zip Code:	Fax Number:
Current License Number:		Licensing State:	
<u>Patient's Diagnosis/Serious Medical Condition:</u>			
<u>Required Treatment for Condition:</u>			
<u>Equipment prescribed and/or required treatment for conditions (If any):</u> (Check all that apply)			
<input type="checkbox"/> Mechanical Ventilator	<input type="checkbox"/> CPAP Machine	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Feeding Pump	<input type="checkbox"/> Nebulizer		
<input type="checkbox"/> Infant Apnea Monitor	<input type="checkbox"/> Hospital Bed		
<input type="checkbox"/> Continuous Oxygen	<input type="checkbox"/> Refrigeration		
<input type="checkbox"/> Home Dialysis	<input type="checkbox"/> HVAC		
<u>Expected Duration of Condition:</u>			
<i>I certify that the above patient has a serious medical condition which is defined as a physical or psychiatric condition that requires medical intervention to prevent further disability, loss of function, or death. Such conditions are characterized by a need for ongoing medical supervision or the consultation of a physician. A serious medical condition carries with it a risk to health beyond that experienced by the majority of children and adults in their day-to-day minor illnesses and injuries. Individuals with a serious medical condition may require administration of specialized treatments and may be dependent on medical technology such as ventilators, dialysis machines, enteral or parenteral nutrition support or continuous oxygen. Medical interventions may include medications with special storage requirements, use of powered equipment, or access to water. I certify that the preceding information is correct.</i>			
Physician's Signature:		Date:	

This form was developed pursuant to: 20VAC 5-330 "Limitations on Disconnection of Electric and Water Service"