



Jackson Electric Cooperative, Inc.

A Touchstone Energy Cooperative

Critical Care or Chronic Condition Status

Please acknowledge you have read the each statement below by placing your initials in the blank provided.

This application must be completed to obtain the designation of Critical Care or Chronic Condition Status with Jackson Electric Cooperative, Inc.

INITIAL

Submission of this application does not automatically result in chronic condition or critical care status.

INITIAL

Designation as a Chronic Condition or Critical Care residential customer does not relieve a customer of the obligation to pay for electrical service, and service may be disconnected for failure to pay.

INITIAL

Chronic condition or critical care status does not guarantee an uninterrupted regular, or continuous power supply. If electricity is necessity, you must make other arrangements for on-site back-up capabilities or other alternatives in the event of loss of electric service.

INITIAL

MEMBER INFORMATION

MEMBER'S NAME: _____

ACCOUNT #: _____

PATIENT'S NAME (IF NOT THE SAME AS ABOVE): _____

MAILING ADDRESS: _____

CITY/STATE/ZIPCODE: _____

Member's Signature

Date

CONTACT INFORMATION

HOME TELEPHONE #: _____

WORK TELEPHONE #: _____

NAME OF NEAREST RELATIVE: _____

TELEPHONE #: _____

Is there back-up power or alternate equipment available? () YES () NO

PHYSICIAN'S INFORMATION <i>(Please answer the following Questions)</i>	
1. Brief description of the type of life support required:	_____
2. Will equipment operate without electric service?	() YES () NO
3. Is there back-up power or alternate equipment available?	() YES () NO
4. Will the disconnection of the electric service be detrimental to patients health?	() YES () NO
5. As of this date is life support equipment in service and required?	() YES () NO
I certify that the above name patient is under my care and requires the life support equipment listed above.	
Physician's Name (PRINT):	_____ Telephone#: _____
Physician's Signature:	_____ Date: _____