MEDICAL CONDITION CERTIFICATION

Please return this form by fax to: 608-252-4754
or mail to:
Madison Gas and Electric Company, Attn.: Customer Assistance, PO Box 1231, Madison, WI 53701-1231

Customer Information

Madison Gas and Electric Company (MGE) Customer Name	Daytime Phone	Evening Phone	
Address	City/Town/Village	State	ZIP
Name of Patient	Patient's Date of Birth	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 MGE and authorize MGE to contact my provider for additional information or clarification for MGE's purpose of evaluating the continuation or reconnection of my electric utility service. I understand that acts of nature, equipment failure, etc., do happen and could result in an unplanned interruption of my utility service and acknowledge that I am responsible for an emergency backup plan.

Signature _____ Date _____

☐ Verbal Authorization by Customer Date _____

Provider Information

Our customer has requested that MGE make every effort to provide continuous utility service because of a medical emergency or 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 questions below.*** Thank you for your time.

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

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

*3. What, if any, electrically powered life-sustaining medical equipment is required or used at the patient's location?
_____

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

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

*6. 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
For MGE Use Only	Added to Database ☐ Yes ☐ No	Initials	Date