



# MEDICAL CONDITION CERTIFICATION

## Customer Information

MGE 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 Madison Gas and Electric Company for the 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. 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 Madison Gas and Electric Company (MGE) make every effort to provide continuous 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. What is the specific medical emergency or protective services emergency that exists for the patient named above? _____	
4. What, if any, electrically powered life-sustaining medical equipment is required or used at the patient's location? _____	
5. How would the interruption of electric service at this patient's location affect the medical emergency or protective services emergency situation? <b>PLEASE BE SPECIFIC.</b> _____	
6. Can the patient use the equipment at another location where electric service is available? <input type="checkbox"/> Yes <input type="checkbox"/> 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: 608-252-4754** OR Mail to: Madison Gas and Electric Company  
 Attn.: Customer Assistance  
 Post Office Box 1231  
 Madison, Wisconsin 53701-1231