



## Medically Essential Service Certification

In order for Okefenokee REMC to determine whether a member is eligible for the designation as a Medically Essential Service Member, Part A must be completed by the member and Part B by the patient's physician. Return the completed form to the Customer Service Department at Okefenokee REMC.

### Part A: Member Application

*Please type or print clearly*

Date: \_\_\_\_\_

Account Number: \_\_\_\_\_ Location Number: \_\_\_\_\_

Member Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Service Address: \_\_\_\_\_

Patient's Name (if not member) using equipment: \_\_\_\_\_  
(patient must be a resident of member's home)

Does the patient have auxiliary power: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, is it battery or generator power? \_\_\_\_\_

Name & Type of equipment: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

OREMC has fully explained how my account will be handled regarding any collection action due to non-payment of the bill. I understand that OREMC does not guarantee uninterrupted service or assign a priority status to my account for service restoration during outages. I understand that I must be prepared with backup equipment and/or power and a planned course of action in the event of power outages. I agree to notify OREMC when this equipment is no longer in use.

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Entered by OREMC Employee: \_\_\_\_\_ Date: \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



## Medically Essential Service Certification

### Part B: Physician's Certificate

*Please type or print clearly*

Physician's Name: \_\_\_\_\_ Physician's License No.: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Phone Number(s): \_\_\_\_\_

I, \_\_\_\_\_ (name of physician), duly licensed and authorized to practice medicine in the State of Florida, hereby certify that \_\_\_\_\_ (patient's name), who resides at \_\_\_\_\_ (patient's place of residence) and who is under my care, relies upon continuously operating electric-powered medical equipment described as follows:

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The patient uses this equipment \_\_\_\_\_ hours within each 24 hour period. Following is the reason(s) in my opinion, this patient needs the continuous use of this equipment in order to sustain his/her life or to avoid serious medical complications requiring his/her immediate hospitalization: [attach additional pages if necessary]

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Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This certificate shall be deemed valid for a period of 12 months from the date the certificate is accepted by OREMC for purpose of determining that a member qualifies as a Medically Essential Service Member as defined by OREMC's policies and procedures, or that such designation should be renewed.