



## MEDICAL ALERT REGISTRATION FORM

### Instructions:

The Medical Alert Registry allows the Cooperative to consider a member's life-threatening health condition dependent on the operation of electrical equipment whenever possible. The Cooperative can provide advance notice of planned disruption for maintenance purposes, provide information to help members make decisions regarding their health and comfort, and help members and their caregivers evaluate the need to evacuate to a shelter or other accommodations in the event of an extended power disruption.

Placement on the Registry does not guarantee uninterrupted service, prevent electric service disruption, or relieve a member's responsibility to maintain an account in good standing. Nor does the registry guarantee that members with severe medical conditions will be able to have their electric service restored following a natural or man-made power disruption without consideration for the greater good and safety of the general public.

### These definitions apply in using this form:

**Medical Emergency Patient** - An existing medical condition of the member or the member's household that will be aggravated by the lack of utility service, as defined and certified by a physician or public health official on this Medical Alert Registration form.

**Critical Care Patient** - An existing medical condition of the member or the member's household that requires home medical equipment or a life support system that is immediately life-threatening during an interruption of service.

### TO MAKE A REQUEST TO BE ADDED TO MEDICAL ALERT REGISTRY:

1. **Section 1** of the Medical Alert Registration Form to be completed by the resident of the household requesting to be added to the registry.
2. **Section 2** of the Medical Alert Registration Form to be completed by Member (Account Holder).
3. **Section 3** of the Medical Alert Registration Form to be completed by a physician or Public Health Official.
4. **Return the completed form:**

Mail: Cuivre River Electric Cooperative  
Attn: Medical Alert  
8757 Highway N  
Lake Saint Louis MO 63367

Fax: 636-695-4701  
Email: CREC@cuivre.com

**NOTE: A new form must be completed every 2 years to stay on the Medical Alert Registry**

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## MEDICAL ALERT REGISTRATION FORM

**TO BE ADDED TO THE REGISTRY, ALL SECTIONS OF THIS FORM MUST BE COMPLETED, LEGIBLE, AND RETURNED TO THE UTILITY. INCOMPLETE FORMS WILL NOT BE CONSIDERED.**

*I understand that Cuivre River Electric Cooperative cannot guarantee continuous utility service and it is my responsibility to maintain a backup system or have an alternate plan in the event of such loss. Use of this form does not provide any rights to the member regarding service restoration in the event of an unexpected outage.*

### Section 1: The following information is to be completed by the Patient

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Relationship to Member (Account Holder) \_\_\_\_\_ Self \_\_\_\_\_ Other \_\_\_\_\_

Primary Phone #: (\_\_\_\_) \_\_\_\_\_ Secondary Phone #: (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

*I hereby authorize my health care provider(s) to release the medical information included on this medical registration form to my utility, or third parties authorized by the utility; to assist with the review, approval, and processing of this request. I understand that continuous utility service is not guaranteed and it is my responsibility to maintain a backup system or have an alternate plan in the event of a loss of utility service. I certify that the patient lives at the address listed below and that all information provided is accurate. If I meet the conditions to be added to the Medical Alert registry, I also agree to notify the cooperative when this is no longer necessary.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient/Legal Guardian/Power of Attorney (POA paperwork required)

### Section 2: The following information is to be completed by the member (Account Holder)

Member Name (printed): \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone #: (\_\_\_\_) \_\_\_\_\_ Secondary Phone #: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Account Number: \_\_\_\_\_

*I certify the information above is accurate AND the patient is the member of record or a household member residing at this address.*

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

Approval of this form does not prevent shut-offs indefinitely. You must take steps to resolve unpaid bills to avoid service interruptions in the future. Questions? Call us at 1-800-392-3709

**Section 3: The following information is to be completed by a Physician or Public Health Official**

**Medical Emergency Patient**

*Patient suffers from an existing medical condition that will be aggravated by the lack of utility service.*

I certify that the patient has the following medical emergency condition(s) that will be aggravated by the loss of electricity.

Condition(s):

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Equipment: \_\_\_\_\_

**Critical Care Patient**

*Patient uses life-supporting medical equipment at home and termination of the utility service would be **immediately life threatening**.*

The following life-support system(s) or medical equipment is/are used by the patient:

Equipment:

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Additional comments (if any):

Check one:  Physician  Public Health Official

Physician Name: \_\_\_\_\_ Job Title (if not physician): \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**I certify that the patient identified on this form has been examined by me and to the best of my knowledge, information provided is true, and that, in checking the selected box and signing this form, the patient meets the criteria of a "Medical Emergency Patient" or a "Critical Care Patient".**

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