Special Health Registration

This form is to be completed by the member of Pella Cooperative Electric and their registered attending physician. By returning this form, your electric account will be flagged for special health concerns. However, this provides no guarantee of uninterrupted electric service, nor does it guarantee priority during service restoration efforts.

This section should be completed by the member of Pella Cooperative Electric:

Account Number ______________________________

Name of Patient ______________________________ Age: ______________

Relationship to member of record: ______________________________

Address: ______________________________
Street City ST Zip

Emergency Contact Name (must NOT reside at same residence): ______________________________

Emergency Contact Phone Number: ______________________________

Pella Cooperative Electric is committed to providing reliable service, but cannot guarantee or insure uninterrupted electrical service. If the individual listed above cannot be without power for any reason, we strongly urge you to development alternate care plans, such as installing a backup power supply. Please consult with your physician or medical supplier about your specific needs. Consideration for health of a resident is governed under Pella Cooperative Electric's tariff section 6.2.2(9), a copy of which can be provided upon request.

Member Signature: ______________________________ Date: ______________

This section should be completed by the registered attending physician:

Physician Name: ______________________ Hospital Affiliation: ______________________

Address: ______________________________
Street City ST Zip

Phone: ______________________ Fax: ______________________

Type of Device:
_______ Infant Apnea Monitor
_______ Ventilator/Respirator
_______Home Dialysis
_______ IV Pumps
_______ Oxygen Concentrator
_______ BIAP (Bi-level Positive Airway Pressure)
_______C-Pap Machine – Minor Child (Continuous Positive Airway Pressure)

How often is the device used? ______________________________

How long is the device used during each treatment? ______________________________

I verify the patient listed above requires the equipment as noted. The use of this equipment is imperative for life support. I further verify that consideration has been given for standby electric supply for continuity of service.

Physician Signature: ______________________________ Date: ______________