

OCALA ELECTRIC UTILITY

APPLICATION FOR MEDICAL ALERT CUSTOMER STATUS

I certify that I have, or someone in my household has, a medical need for electricity. This condition is certified by a licensed physician practicing in the State of Florida. I understand that it is my responsibility to pay any outstanding utility bills to Ocala Electric Utility and that failure to do so will result in termination of utility services. I also understand that electricity served to my residence is subject to unscheduled interruptions and that it is my responsibility to report them to the Ocala Electric Utility.

Utility Account #

Date Signed

Service Address

City

State

Zip

Print or Type Name of Person
With Medical Need

Signature of Person, Parent or Guardian
of Person With Medical Need

PHYSICIAN'S STATEMENT OF CERTIFICATION

Note to Physician: Please complete all spaces provided

This is to certify that _____ has a medical need for electricity and could suffer life threatening conditions if without electricity for more than _____ hours. Due to this condition, I recommend that electricity not be intentionally interrupted without prior notification. This is effective _____ through _____.

Date

Date

Physician's Name

Physician's Address

Physician's Telephone Number

Physician's License or Certification Number

Physician's Signature

Note: This special service is subject to expiration on or after the date provided by the licensed physician. All Medical Alert Applications are reviewed annually.