



Medical alert verification form

St. Croix Electric account number: _____

Name: _____

Address: _____

Medical priority condition: _____

Effective date: _____

Duration: _____

Physician name (printed): _____

Physician signature: _____

Physician/clinic phone number: _____

Print and complete this form. Mail it to: St. Croix Electric Cooperative, 1925 Ridgeway Street, Hammond, WI 54015. Call with questions: 715-796-7000.