1925 Ridgeway St. | Hammond, WI 54015
715-796-7000 | www.scecnet.net
This institution is an equal opportunity provider.

SCEC Medical Priority Request Form

Member's Name: ______________________________ Account#: ___________________

Patient's Name: ____

Address: ____

Phone: ____________________________E-mail: _________________________________

I hereby authorize my health care provider(s) to release the medical information included on this form to my utility to assist with the 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.

Patient's Signature: ____Date: ____________

(The information below must be completed by a physician)

Please place ____________________________ on your Medical Priority List for restoration of service if a power failure should occur at the aforementioned address.

This patient is currently under my care, and uses the following life-supporting medical equipment at the home: ____

The equipment in use is electrically powered and may or may not have battery support.

Duration of Need: (Please choose one)

- ☐ Permanent
- ☐ Temporary _______________ (end date)

Physician's Name: ____

Business Address: ____

Business Phone: _________________________ Fax: _________________________

I certify that the patient identified on this form is currently under my care and to the best of my knowledge, the information provided is true.

Physician's Signature: _____________________________________Date: ____________