



1925 Ridgeway St. | Hammond, WI 54015  
715-796-7000 | 800-924-3407 | www.scecnet.net  
*This institution is an equal opportunity provider.*

A Touchstone Energy<sup>®</sup> Cooperative 

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 ( \_\_\_ / \_\_\_ / \_\_\_ )

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: \_\_\_\_\_