Victoria Electric Cooperative Critical Care Account Form

Member Account Number: ___________________________  Meter #____________________

Name of Account Holder:  ___________________________________________________________

Name of Critical Care Person:  ________________________________________________________

Relationship to Account holder:  _____Self     ____Spouse     ____Parent     _____Renter

_____ Other – please specify: _________________________________________________________

Contact information: Please include both day and evening numbers:

Telephone number(s) of Account Holder:  ________________________________________________

Telephone number(s) of Critical Care Provider or live-in caregiver, if different from Account Holder:

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TO BE COMPLETED BY PHYSICIAN – PLEASE TYPE:

Description of Patient’s Condition:  _________________________________________________

___________________________________________________________________________________

Critical medical equipment at the residence requiring electric power for operations:

___________________________________________________________________________________

Name of Physician:  __________________________________________________________________

Name of Medical Facility at which Physician Practices:  ___________________________________

___________________________________________________________________________________

Physician’s Mailing Address:  _________________________________________________________

___________________________________________________________________________________

Physician’s Phone Number:  ___________________________________________________________

Note to Physician:  With regard to planning power outages, Victoria Electric Cooperative (VEC) will attempt to contact your patient requiring electrically-powered medical equipment in advance so that they can make arrangement for transport to another location, if necessary. However, because of the wide variety of circumstances under which (unplanned) outages occur, VEC cannot guarantee restoration time. If your patient has critically important medical equipment that requires electric power for operations, they should have a back-up source of power available at their residence.

_________________________________________ ________________________________

Signature of Licensed Medical Doctor   Date Signed

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