30-Day Medical Certification
Caney Fork Electric Cooperative, Inc.

Instructions:

The following is to be completed by a licensed medical professional and only after you, or someone in your office, has examined the individual whose name appears as the patient on the form below. This form applies only in situations where, in your professional opinion, termination of electric utility service would be especially dangerous to the health of that individual. If, in your professional opinion an especially dangerous situation does not exist, please do not sign this form.

If you have any questions regarding this form, please contact Caney Fork Electric Cooperative at (931) 473-3116. You may fax the completed form to us at (931) 473-4939 or send via the postal service to P.O. Box 272, McMinnville, TN 37111.

I certify that, to the best of my knowledge, the information provided below is true.

The following medical information must be certified by one of the following. Please indicate if you are:

_____ Licensed physician _____ Physician Assistant

_____ Clinical Nurse Specialist _____ Certified Nurse Practitioner

_____ Certified Nurse-Midwife _____ Local Board of Health Physician

Please complete the following. Please print.

I certify that my patient has been examined by me and I have determined the following to be true:

Name of Patient: _____

Patient's Permanent Residence: (street address) _____

(city, state, zip code) _____

Check the applicable condition:

_____ **This patient suffers from a hazardous medical condition and termination of electric utility service would be especially dangerous of life-threatening.**

_____ **This patient uses medical or life-supporting equipment and termination of electric utility service would make operation of that equipment impossible or impractical.**

I certify that I advised my patient that disclosure of the requested information may be subject to re-disclosure by the recipient and no longer protected by the HIPAA rules and regulations.

Authorized Signature _____

Date _____

(Please Print)

Name of Licensed Medical Professional _____

Business Address _____

Business Telephone _____

Current State License or Certificate Number _____

All sections must be fully completed in order to process the medical certification request.