WAUNAKEE UTILITIES
ESTABLISHED 1915

Medical Alert Customer Application

Please fill out the top half of this form and have your medical, social service, and/or law enforcement provider complete the bottom half of the form and fax it to us at 608-849-4109 within 5 days. **Acceptance into this program does not guarantee continuous electrical service, nor does it protect your account from collection action for unpaid utility bills. If your service is critical for life support, you should develop a medical backup plan to accommodate your medical needs during power interruptions.**

Customer Information (To be completed by customer)

Name_____ Account Number _____

Address _____ Daytime Phone _____

City _____State_____Zip _____ Evening Phone _____

Individual(s) with critical medical condition, life-support equipment or under protective services emergency

Name _____ Name_____

Date of Birth _____ Date of Birth_____

Third-party contact person _____

Third-party contact daytime phone number _____

Release (signed by patient with condition or his/her legal guardian)

I _____ (circle one: resident or legal guardian) hereby grant my consent to the below name licensed physician or public health, social services, or law enforcement official, as well as my third party contact person, to release to Waunakee Utilities such information as noted below, plus any supplemental information as may be needed by Waunakee Utilities to verify the medical need for Medical Alert Services.

Signature of resident or legal guardian _____ Date ____/____/_____

Provider Information (To be completed by medical, social service or law enforcement provider)

Name _____ Title/specialty_____

Organization _____ Office Hours _____

Address _____ Phone _____

City _____State _____ Zip_____ Fax_____

Patient name _____ Date of last office visit _____/_____/_____

Critically ill condition* No Yes Explain _____

Life-support equipment* No Yes Explain _____

Is the patient (or caretaker, in the case of small children) ambulatory? (Circle one) YES NO

Level of patient functionality (circle one) Independent Needs assistance w/ADL Dependent Care

Note the presence of in-home (circle those that apply) Skilled nursing Physical therapy Hospice

Please describe critical medical condition and/or life support equipment needs _____

_____

*** Assume the standard accepted medical definition of "Critically ill" & "life-support" for qualifying patients for this service.**

Physicians Signature _____Date_____ License # _____

322 Moravian Valley Road, PO Box 70, Waunakee, WI 53597
(608) 849-8111, Fax (608) 849-4109, www.waunakeeutilities.com