Freeborn Mower Electric Cooperative
People. Power. Possibilities.

LIFE-SUSTAINING MEDICALLY NECESSARY EQUIPMENT FORM

MEMBER CERTIFICAITON *(To be completed by member)*

Member Name:_____FMEC Account #:_____

Member Address:_____

City:_____State:_____ Zip:_____

Phone:_____Other Phone:_____

Resident(s) requiring life-sustaining necessary equipment:_____

Relationship to Member:_____

RELEASE *(To be completed by Resident requiring life-sustaining equipment or his/her legal guardian)*

I,_____(circle one: resident or legal guardian) herby grant my consent to the below-named licensed physician to release to Freeborn Mower Electric Cooperative, the information below.

Signature of Resident or Legal Guardian:_____Date:_____

MEDICAL VERIFICAITOIN *(To be completed and signed by a licensed medical provider)*

I certify that the termination of electricity would disrupt the use of life-sustaining medically necessary equipment and would create a medical emergency for:

Patient Name:_____

Patient Address:_____

Physician Name:_____Medical Facility:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____Email:_____

Signature:_____Date:_____

Please fax or mail completed form to:
Freeborn Mower Electric Cooperative
PO Box 611, Albert Lea, MN 56007
Fax: (507) 369-0259