DELAWARE ELECTRIC CO-OP
"We Keep the Lights On"

14198 Sussex Highway
Greenwood, Delaware 19950
855-332-9090
www.delaware.coop

MEMBER CERTIFICATION OF MEDICAL NEED

Note to Member: The Medical Provider's portion of this form must be completed and signed by a licensed physician, physician assistant or advanced nurse practitioner.

Certification will be effective for 120 days from date of Medical Provider signature.

The Member must complete this portion of the form completely and accurately.

Member and Patient Information

Name of Delaware Electric Cooperative Member(s): _____

Delaware Electric Cooperative Account Number: _____

Service Address: _____

Phone Number: _____

Patient residing at above address that requires service: _____

By signing this form, I certify that the patient listed on this Certification resides full-time at the address and requires electric for medical need. I understand that I, as the Member, am still responsible for the charges that accrue on my electric account and that this does not alleviate my responsibilities to make payments on my account. I further understand that this Certification of Medical Need is effective for 120 days, must be renewed and resubmitted and good faith effort to make payments must be made. I also certify under oath that the information listed on this form is true and correct and consent to the information being kept on file by the Cooperative.

Member Signature: _____ Date: _____ Patient Signature**: _____ Date: _____

****Parent or Guardian if patient is a minor**

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MEDICAL PROVIDER CERTIFICATION

Note to Medical Provider: This Certification is required to inform Delaware Electric Cooperative that termination of the sale or service of electricity to the patient listed on the previous page will adversely affect the health and/or recovery of that patient.

Medical Provider's Information

Name: _____

State of licensure & number: _____

Practice and/or specialties: _____

Office Address: _____

Phone Number: _____

I, Medical Provider, certify that the patient listed above is under my care and the information provided by me herein is true and accurate. I also certify, to the best of my knowledge, that the address listed above for the patient matches the address listed in my files and records.

Medical Provider Signature: _____

Date: _____

Note to Member: Please complete and return completed form to:

Delaware Electric Cooperative
Member Service Department
14198 Sussex Highway
Greenwood, DE 19950