Victoria Electric Cooperative
Your Touchstone Energy® Cooperative

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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**