West Florida Electric
A Touchstone Energy® Cooperative
The power of human connections
www.westflorida.coop

MEDICALLY ESSENTIAL SERVICE APPLICATION

I certify that I have a medical need for electricity. This condition is certified by a licensed physician**. I understand that it is my responsibility to pay any outstanding utility bill to the Cooperative and that failure to do so will result in termination of utility services. West Florida Electric has fully explained how my account will be handled regarding any collection action due to non-payment of the bill. I also understand that electricity served to my residence is subject to unscheduled interruptions and that it is my responsibility to report them to the Cooperative.**

The Cooperative cannot and does not express or imply that it provides uninterrupted electrical power. The Cooperative advises the patient or account holder to provide for an alternate source of care or electricity in the event electrical service to their location is interrupted.

Member Name: ____ Account #: ____________________________

Service Address: ____

Primary Phone #: _________________________ Secondary Phone #: _______________________________________

Text Alerts: ☐ Yes ☐ No E-Mail Alerts: ☐ Yes ☐ No E-mail Address: _______________________________________

Alternate Contact: ___________________________________Alternate Contact Phone #: _______________________

Member Signature: ____ Date: ____________________________

By signing above the Member acknowledges responsibility to provide necessary accommodations during a service interruption, either through an alternate power source or location. The member also acknowledges this form must be resubmitted annually, the Cooperative must be notified if Medical Essential Service changes.

Physicians Statement of Certification

This is to certify that _______________________________ has a medical need for electricity and could suffer life threatening conditions if without electricity for more than ________ hours. The patient has been advised of the effects of being without electricity as it pertains to their medical condition; alternate options for the patient in the event of an extended interruption in power have been reviewed.

Physician's Name: __________________________________ Physician's Phone #: _________________________

Office Address: ____

Physician's License or Certification #____

Physician's Signature: ____ Date: ___________________

To Report Power Outages, Call WFEC's
24 Hour Hotline Number:

1.844.688.2431