MEDICAL CONDITION CERTIFICATION

Beloit Utilities ● City Treasurer's Office
100 State Street, Beloit, WI 53511
Office: (608) 364-6663 Fax (608) 364-6642

INSTRUCTIONS: This form allows a Beloit Utilities account holder to request a 21-day extension of a pending disconnection of services by providing information related to the circumstances of a medical emergency, equipment, or under protective services emergency. This form must be filed with the City Treasurer's Office.

Serviced Property Information

Address:	City/ST/Zip:	Account Number

Account Holder Information

Name:	Phone:

Address:	City/ST/Zip:

Patient or Person with Medical Emergency, Equipment, or Under Protective Services Emergency

Name:	Relationship to Account Holder:

Legal Guardian or Power of Attorney (if any):	Phone:

Medical/Social Service/Law Enforcement Provider Information

Name:	Title/Specialty:
Organization:	Phone: Fax:
Address:	City/ST/Zip:

Authorization

I, the above-named patient or person with a medical emergency, equipment, or under protective services emergency, hereby authorize my medical or social service provider, and/or law enforcement agency to disclose the following information to Beloit Utilities or to answer any related questions for the purpose of evaluating the continuation or reconnection of my utility service. I understand that acts of nature, equipment failure, etc., do occur and could result in an unplanned interruption of my utility service. I also acknowledge that I am responsible for an emergency backup plan.

Signature: Date:

Provider Information (to be completed by the Physician/Social Service Provider/Law Enforcement Agency)

The above-named Beloit Utilities customer has requested a 21-day extension of utility services because of a medical emergency or a protective services emergency. In order to process this request, information from you as the medical, social service or law enforcement provider is required. Please complete this form and return it to Beloit Utilities by fax or mail. Please answer all seven questions. Attach additional sheets if needed.

1. Patient's/Subject's Date of Birth		2. Is there a medical emergency or protective services emergency present in the household?	Yes	No

3. What is the specific medical emergency or protective services emergency that exists for your patient/subject named above?

4. What, if any, life-sustaining medical equipment is required or used at your patient's/subject's residence?

5. How would the interruption of water and sewer service at this patient's residence affect the medical emergency or protective services situation? Please be specific.

6. Can such equipment be used at another location where water and sewer service is available? If no, please explain.

7. What is the expected duration of the medical emergency or protective services emergency situation?

Provider Certification

I certify that all of the information above is true, correct and complete to the best of my knowledge and belief.

Provider Signature: Date:

Provider Printed Name: _____ Phone Number:

Please return this form by fax to (608) 364-6642 or by mail to Beloit Utilities, 100 State Street, Beloit WI 53511

Revised 01/1/2018