



Critical Life-Sustaining Medical Equipment Form

Wisconsin Residential

I. Customer certification To be completed by customer

Customer name _____ Account number _____
Customer address _____ City _____ State _____ ZIP _____
Home phone _____ Business phone _____
Email _____
Resident requiring life sustaining medical equipment _____ DOB _____
Relationship to customer _____

II. Release To be completed by resident requiring life-sustaining medical equipment or his/her legal guardian

I _____ (Check one: Resident or Legal Guardian) hereby grant my consent to the below-named licensed physician or public health, social services, or law enforcement official to release to Xcel Energy such information as noted below, plus any supplemental information regarding critical medical equipment used at the residence.

Signature of resident or legal guardian _____ Date _____

III. Medical verification To be completed and signed by a licensed physician, public health, social services, or law enforcement official

The above named customer is currently using one of the following LIFE-SUSTAINING medical devices.

- | | | |
|--|--|--|
| <input type="checkbox"/> Ventilator | <input type="checkbox"/> Heart monitor | <input type="checkbox"/> Other: Critical life sustaining medical devices |
| <input type="checkbox"/> Infusion pump | <input type="checkbox"/> Feeding pump | <input type="checkbox"/> Other: Not life sustaining |
| <input type="checkbox"/> Kidney dialysis | <input type="checkbox"/> Oxygen concentrator | |
| <input type="checkbox"/> Respirator | <input type="checkbox"/> Suction machine | |

*If you have selected Other: Critical Life Sustaining, Xcel Energy requires an explanation of the Life Support equipment that is used at this residence:

I certify that the termination of electricity would disrupt the use of LIFE SUPPORT EQUIPMENT and would create a emergency for _____ who is a permanent resident at _____

Physician name _____ Title _____

Clinic/hospital name _____ Phone _____

Address _____ City _____ State _____ ZIP _____

Signature of resident or legal guardian _____ Date _____
(Needs to be signed by a licensed physician, public health, social services, or law enforcement official)

Please mail or fax completed form to:

Xcel Energy
Attn: PAR DEPARTMENT
P.O. Box 8
Eau Claire WI 54702
Fax: 612-573-1700