

**CERTIFICATE OF MEDICAL EMERGENCY**

Customer Name \_\_\_\_\_

Service Location \_\_\_\_\_

Number and Street or Rural Route

(if different from service location) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (    ) \_\_\_\_\_

BCES Account Number \_\_\_\_\_

Customer Social Security Number \_\_\_\_\_ or

Customer Driver License Number \_\_\_\_\_

Person in Household with Medical Emergency \_\_\_\_\_

Relationship to Customer Name Listed Above \_\_\_\_\_

**STATEMENT OF LICENSED PHYSICIAN ONLY**

By my signature, given below, I certify that my records indicate that \_\_\_\_\_, who is currently under my care, resides at the above referenced household. I further certify that the discontinuance of electric utility service to this household would create a medical emergency and possible death.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_ PHONE # (    ) \_\_\_\_\_

**NOTE: THIS STATEMENT DOES NOT IN ANY WAY REMOVE THE OBLIGATION TO PAY FOR SERVICES RECEIVED OR TO BE RECEIVED FROM BENTON COUNTY ELECTRIC SYSTEM. THIS FORM MUST BE UPDATED ON AN ANNUAL BASIS.**