FREEBORN MOWER COOPERATIVE SERVICES
LIFE-SUSTAINING MEDICALLY NECESSARY EQUIPMENT FORM

MEMBER CERTIFICATION: (To be completed by member)

Member Name: _____ **Account #** _____

Member Address: _____

City, State, Zip: _____

Home Phone: _____ **Business Phone:** _____

Resident(s) requiring *life-sustaining medically necessary equipment*: _____

Relationship to Member: _____

RELEASE: (to be completed by Resident requiring life-sustaining equipment or his/her legal guardian)

I _____ (circle one: resident or legal guardian) hereby grant my consent to the below-named licensed physician to release to *Freeborn Mower Cooperative Services*, the information below.

Signature of Resident or Legal Guardian: _____ Date: _____

MEDICAL VERIFICATION (To be completed and signed by a licensed medical provider)

I certify that the termination of electricity would disrupt the use of LIFE-SUSTAINING MEDICALLY NECESSARY EQUIPMENT and would create a medical emergency for

_____

who is a permanent resident at: _____

_____

Physician Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Signature: _____ **Phone:** _____

Please fax or mail completed form to:
FREEBORN MOWER COOPERATIVE SERVICES
PO BOX 611
ALBERT LEA, MN 56007
FAX: 507-369-0259