FAYETTE ELECTRIC COOPERATIVE, INC.
Your Touchstone Energy® Cooperative

ACCOUNT NUMBER

DATE

APPLICATION FOR CRITICAL CARE RESIDENTIAL MEMBER STATUS

TO BE COMPLETED BY MEMBER:

FEC maintains a record of members dependent upon electrical life support systems. A Life Support Dependent Member is a person who has been prescribed by a physician, licensed by the State of Texas as a Medical Doctor, or a Doctor of Osteopathy, an electrical device and/or equipment designed to sustain that person's life. Persons designated as Life Support Dependent Members should complete the member portion of this form and have their doctor complete the physician's portion. When completed, return this form to FEC's office.

NAME AS IT APPEARS ON YOUR BILL: _____

MAP NUMBER AS IT APPEARS ON YOUR BILL: _____

911 SERVICE ADDRESS: _____

PATIENT'S NAME: _____

PRIMARY CONTACT PERSON TO NOTIFY: _____

PRIMARY PHONE #: _____ ***SECONDARY PHONE #:*** _____

SECONDARY CONTACT PERSON TO NOTIFY: _____

PRIMARY PHONE #: _____ ***SECONDARY PHONE #:*** _____

TERTIARY CONTACT PERSON TO NOTIFY: _____

PRIMARY PHONE #: _____ ***SECONDARY PHONE #:*** _____

DESCRIPTION OF BACKUP LIFE SUPPORT SYSTEM(S) IN THE EVENT OF A LOSS OF NORMAL ELECTRICAL SERVICE AND THE RUN-TIME (I.E. BACKUP GENERATOR, PORTABLE OXYGEN DEVICE, ETC.): _____

_____

OTHER INFORMATION OR COMMENTS: _____

_____

INFORMATION PROVIDED BY: _____ ***PHONE #:*** _____

MEMBER:
I have read and understand the information and certify that the information provided on this application is correct.

Member understands that he/she secures no special right to preferential service because FEC has created a system to take into account member's special needs and that FEC in no way guarantees uninterrupted service. Member is also advised that it is important that he/she make alternative arrangements in the event of an interruption in the normal electrical service.

SIGNATURE: _____ ***DATE:*** _____

PATIENT OR PATIENT'S GUARDIAN, PARENT OR MANAGING CONSERVATOR:
I have read and understand the information and certify that the information provided in this application about me (or the patient) is correct. I agree to the release of the information on this form concerning my (or the patient's) medical condition for the purposes stated on this application.

SIGNATURE: _____ ***DATE:*** _____
(Signature required, even if same person as Member)

TO BE COMPLETED BY PATIENT'S PHYSICIAN:

DESCRIPTION OF ILLNESS: _____

DESCRIPTION OF LIFE SUPPORT EQUIPMENT: _____

PRESCRIBED USE OF LIFE SUPPORT EQUIPMENT: _____

OTHER INFORMATION OR COMMENTS: _____

_____

PHYSICIAN NAME (printed): _____

TEXAS MEDICAL BOARD LICENSE NUMBER: _____ ***PHONE :*** _____

ADDRESS: _____

PHYSICIAN SIGNATURE: _____ ***DATE:*** _____

PLEASE NOTIFY FEC IF LIFE SUPPORT DEPENDENT INFORMATION CHANGES OR IF THE CLASSIFICATION IS NO LONGER NEEDED.

Fayette Electric Cooperative wants to maintain an accurate and up-to-date list of all life support systems on its lines. This form will be saved for two years, after which time it will need to be renewed. This information can be life saving! If you have any questions, please contact the Operations Department at 979-968-3181.

Revised April 2019