CITY OF OCALA MUNICIPAL SERVICES

APPLICATION FOR MEDICAL ALERT CUSTOMER STATUS

PART A: CUSTOMER APPLICATION

**********PLEASE TYPE OR PRINT CLEARLY**********

Date: _____ Account Number: _____

Customer Name: _____ Last 4 digits of Social Security No. _____

Service Address: _____ City: _____ Zip Code: _____

Home Telephone No.: _____ Daytime Telephone No.: _____

Email Address: _____

I, _____ [Customer Name] certify that I or someone in my household has a medical need for electricity and the condition is certified by a State of Florida licensed physician. I understand that it is my responsibility to pay any outstanding utility bills to Ocala Municipal Services, failure to do so will result in termination of utility service. I understand that Ocala Municipal Services does not guarantee uninterrupted service or assign priority status to my account for service restoration due to outages. I understand that I must be prepared with backup equipment or a planned course of action in the event of prolonged outages. I agree to notify Ocala Municipal Services when this equipment is no longer in use.

Name of Person with Medical Need: _____

Customer Signature: _____ Date: _____

WARNING – PART A – CUSTOMER APPLICATION: Knowingly making a false or misleading statement in completing the Customer Application could result in the denial or termination of medical alert status.

***This special service is subject to expiration on or after the date provided by the licensed physician. **Medical Alert Applications are renewed annually.** ***

CITY OF OCALA MUNICIPAL SERVICES

APPLICATION FOR MEDICAL ALERT CUSTOMER STATUS

PART B: PHYSICIAN'S CERTIFICATION

**********PLEASE TYPE OR PRINT CLEARLY**********

Physician's Name: _____

Physician's License Number: _____

Physician's Address: _____ City: _____ Zip Code: _____

Physician's Telephone No.: _____

I, [Physician Name] _____, duly licensed and authorized to practice medicine in the State of Florida, hereby certify that [Customer Name] _____, is under my care and relies upon continuously operating electric-powered medical equipment in order to sustain his/her life or to avoid serious medical complications requiring his/her immediate hospitalization. The patient uses this electric-powered medical equipment ___ hour(s) within a twenty-four (24) hour period. I recommend that electricity not be intentionally interrupted without prior notification.

Physician's Signature: _____ Date: _____

False certification of medically essential service by a physician is a violation of section 458.331(1)(h) or 459.015(1)(i), Florida Statutes, and as such is grounds for disciplinary action by the Board of Medicine or Osteopathic Medicine. This certificate shall be deemed valid for a period of twelve (12) months from the date the customer is determined to qualify as a Medical Alert Customer within the meaning of this Policy.

Note to Physician - Please return Part A and B of the application packet to:

City of Ocala Municipal Services
201 SE 3rd St
Ocala, FL 34471
Phone: 352-629-CITY (2489)
Fax: 352-629-1381
Email: OEU@ocalafl.org

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