931-684-7171 Phone
Shelbyvillepower.com

308 S. Main Street
Shelbyville, TN 37160

Life Support Program – Medical Necessity Form

By completing this form and having a physician sign and certify that loss of electric service would create a life-threatening situation, SPWS can enroll you in the Life Support Program. Upon verification, your individual electric account will be flagged as "life support" which will keep our employees updated on your account's status. While there is not a guarantee of service, the program allows SPWS to be attentive to enrolled customers in the case of weather-related outage situations.

Customer Information

SPWS Account #: ________________________ Account Holder Name: __________________________

Patient Name: _______________________________________ Phone #: _________________________

Service Address:

____

City, State: ____ Zip Code: _________________________

I hereby confirm, acknowledge and agree that:

1. The below listed doctor may release medical information needed to process SPWS Life Support Program enrollment and certification.
2. This medical necessity form must be completed by a medical doctor or nurse practitioner licensed to practice in the state of Tennessee certifying that the loss of electric service would create a life-threatening medical situation for the customer or other permanent resident of the customer's household. It is the responsibility of the customer to ensure that this form has been approved by SPWS.

Signature of Account Holder: ____________________________________ Date: ________________

Signature of Patient: ____ Date: ________________

Physician's Certification

I certify that I am a licensed medical doctor and that the patient listed above is under my care, and in my professional medical opinion, disconnection of electric service would create a life-threatening medical situation due to the following:

[Please explain illness/condition and/ or the necessary life sustaining devise below.]

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I certify that the information contained herein is, to the best of my knowledge, complete, accurate, and supported in the medical records of the patient. I agree to provide updates and additional details as to the specific need for electric service due to the patient's condition or treatment upon request.

Physician Name (print): __________________________ TN License #: _____________________

Physician Signature: _________________________ Physician Phone: _______________________