Medical Alert
Customer Application

Please fill out the top half of this form and have your medical provider complete the bottom portion of this form and return it to the Menasha Health Department, 100 Main St., Menasha, or by fax (920) 967-5247 within five days. **Enrollment does not guarantee continuous electric service, nor does it protect your account from disconnection/collection action for unpaid electric bills. If your service is critical for life support, you should develop a back-up plan to accommodate your medical needs during power interruptions. A new form must be completed each calendar year. This form provides ONE up to 21 day extension to make alternative arrangements for your critical electrical needs or to make acceptable payment arrangements on your account balance. Payment arrangements must be made in person at our office between 7:30 am and 4:00 pm Monday through Friday.**

Customer Information (To be completed by customer)

Name: _____ Account number: _____

Address _____ Daytime phone: _____

City _____ Evening phone: _____

Individual(s) with critical medical condition, life-support equipment or under protective services emergency:

Name: _____ Name: _____

Date of birth: _____ Date of birth: _____

Relationship to customer: _____ Relationship to customer: _____

Third-party contact person: _____

Third-party contact daytime phone number: _____

Release (Signed by patient with condition, or his/her legal guardian)

I _____ (circle one: resident or legal guardian) hereby grant my consent to the attending licensed physician as well as my third-party contact person, to release to Menasha Utilities and the Menasha Health Dept. the information as noted below, plus any supplemental information as may be needed by Menasha Utilities and the Menasha Health Dept. to verify the medical need for Medical Alert Program.

Signature of resident or legal guardian: _____ Date: _____

Provider information (To be completed by medical provider.)

Name: _____ Title/Speciality: _____

Organization: _____ Office hours: _____

Address: _____ Phone: _____

City: _____State _____Zip _____ Fax: _____

Patient Name: _____ Date of last office visit: _____

Critical medical condition*? □ Yes □ No Explain: _____

Life-support equipment*? □ Yes □ No Explain: _____

Asthma Severity/COPD Assessment (only if applicable):

□ Infrequent episode □ Frequent episode □ Mild persistent □ Moderate persistent □ Severe persistent

***Assume the standard accepted medical definition of "critically ill" and "life-support" for qualifying patients for this service.**

Please describe critical medical condition and/or life support equipment needs:

Physician's Signature: _____ License #: _____ Date_____

Menasha Health Dept Signature: _____ Date_____