**MEDICALLY ESSENTIAL SERVICE**
**CERTIFICATION FORM**

Main Phone (305) 295-1000 Customer Service Phone (305) 295-1090 Customer Service Fax (305) 295-1085

## PART A: CUSTOMER APPLICATION

Date: _____ Account Number: _____

Customer Name: _____

Service Address: _____

City/State/Zip: _____

Cell Phone Number: _____Phone Number: _____

Name of Person Using Equipment: _____

Physician's Name: _____

By signing this application, _____ is acknowledging that application and the conditions have been reviewed in their entirety. KEYS has fully explained how my account will be handled regarding any collection action due to nonpayment of the bill. I understand that KEYS does not guarantee uninterrupted service or assign a priority status to my account for service restoration due to outages. I understand that I must be prepared with backup equipment and/or power and a planned course of action in the event of prolonged outages. I agree to notify KEYS when this equipment is no longer in use.

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 the medically essential service application.

**PART B: PHYSICIAN'S CERTIFICATE**
**(To be Completed by Physician)**

Physician's Name: _____ Physician's License Number: _____

Physician's Address: _____

Physician's Telephone Number: _____

I, _____, duly licensed and authorized to practice medicine in the State of Florida, hereby certify that_____ , who resides at _____, 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 continuously operating medical equipment upon which this patient relies is described as follows:

_____

_____

The patient uses this equipment ___ hour(s) within a twenty-four (24) hour period. The following is an explanation of why, in my professional opinion, this patient needs to use this equipment continuously in order to sustain his/her life or to avoid serious medical complications requiring his/her immediate hospitalization:

_____

_____

_____

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 12 months from the date the customer is determined to qualify as a Medically Essential Service Customer within the meaning of this Policy.

**Return Certification Form to:**
**Keys Energy Services**
**Medically Essential Service**
**Attention: Safety and Risk Coordinator**
**P.O. Box 6100**
**Key West, FL 33041-6100**

If you are in need of financial assistance, please visit our website at www.keysenergy.com/medicallyessential