Brainerd Public Utilities
8027 Highland Scenic Road
P.O. Box 373
Brainerd, MN 56401-0373

Phone (218) 829-8726
Fax (218) 829-4703

Physician's Certification of Illness form for Brainerd Public Utilities Customers

Brainerd Public Utilities Acct #: _____

Date:_____20____

TO BE COMPLETED BY PHYSICIAN

One of our customers has applied to Brainerd Public Utilities (BPU) for protection against termination of his or her electric service because he/she, or someone within the household, is suffering from a **serious illness or life threatening condition**. In accordance with Minnesota Statutes 216B.098, BPU will enroll your patient in our medical protection plan provided you, as a registered physician, certifies in writing that he/she, or someone in the household, is suffering from a **serious illness or a life threatening condition.** Therefore, it is necessary that you provide BPU with the following information:

Please Print Please Print Please Print

Patient's Name _____ **Phone #** (_____)_____

Patient's Address _____ **Brainerd, MN 56401**

1. Does the **above individual** have a medical necessity for **life** sustaining equipment? **Yes** **No**
2. Does patient have **backup generation equipment** available? **Yes** **No**
3. Does patient: live alone **OR** live with someone who can provide needed assistance?

If **yes to question 1,** please check the appropriate qualifying equipment box below.

O Feeding Pump **O** Heart Monitor **O** Infusion Pump **O** Kidney Dialysis **O** Oxygen Concentrator

O Respirator **O** Sleep Apnea **O** Suction Machine **O** Ventilator

O Other Critical Life Sustaining (equipment used)_____

O NON Life Sustaining (equipment used)_____

Is the equipment expected to be needed: **short term** Less then 2 months **Long term** Estimated Length of Need_____/_____/20____

Physician's Name _____**License Number**_____

Address_____**State:** _____ **Zip Code:** _____

Office #(_____)_____ **Fax #** (_____)_____

Physician's Signature_____ **Date**_____/_____/20_____

Please complete and mail or fax this form to Brainerd Public Utilities within five (5) days of receipt.

Brainerd Public Utilities
PO Box 373
Brainerd, MN 56401

218-829-4703 (Fax)

THIS MEDICAL CERTIFICATE IS VALID FOR A PERIOD NOT TO EXCEED 30 DAYS FROM THE DATE SIGNED