30-DAY MEDICAL CERTIFICATION OF ILLNESS OH

FORM NO. 1008 (REV. 09-19)

FirstEnergy

Ohio Edison • The Illuminating Company • Toledo Edison

CUSTOMER INFORMATION

PREMISE NO.			
CUSTOMER OF RECORD			
CUSTOMER'S SERVICE ADDRESS			
CITY	STATE	ZIP CODE	CUSTOMER'S PHONE NUMBER(S)

Instructions:

The following is to be completed by a licensed medical professional and only after you, or someone in your office, has examined the individual whose name appears as the patient on the form below. This form applies only in situations where, in your professional opinion, termination of electric service would be especially dangerous to the health of that individual. If, in your professional opinion an especially dangerous situation does not exist, please do not sign this form.

If you have any questions regarding this form, please contact: the FirstEnergy Medical Certification Hotline at 1-866-596-1783.

You may fax the completed form to us at 1-330-245-5751.

I certify that, to the best of my knowledge, the information provided below is true.

MEDICAL INFORMATION

The following medical information must be certified by one of the following. Please indicate if you are a:

☐ Licensed Physician ☐ Physician Assistant ☐ Clinical Nurse Specialist

☐ Certified Nurse Practitioner ☐ Certified Nurse-Midwife ☐ Local Board of Health Physician

PATIENT INFORMATION

Please complete the following. (Please print.) I certify that my patient has been examined by me and I have found the following to be true:

PATIENT'S NAME		
PROVIDE THE PATIENT'S PERMANENT RESIDENCE	STREET ADDRESS	
CITY	STATE	ZIP CODE

Check the box of the applicable condition:

☐ This patient suffers from a hazardous medical condition and termination of the electric utility service would be especially dangerous or life-threatening.

☐ This patient uses medical or life-supporting equipment and termination of the electric utility service would make operation of that equipment impossible or impractical.

I certify that I advised my patient that disclosure of the requested information may be subject to redisclosure by the recipient and no longer be protected by the HIPAA rules and regulations.

All sections must be fully completed in order to process the medical certification request.

AUTHORIZED SIGNATURE	DATE
NAME OF LICENSED MEDICAL PROFESSIONAL (PLEASE PRINT)	
BUSINESS ADDRESS	
BUSINESS TELEPHONE NO.	CURRENT STATE LICENSE OR CERTIFICATE NUMBER