## Holmes-Wayne Electric Cooperative, Inc.
## Medical Awareness Certification

**If you or someone in your home is dependent on medical equipment operated by electricity, please provide the following information.**

Name_____ Map Location_____

Address_____ Phone Number_____

_____ Cell Phone _____

**We request the attending physician please complete and certify the following information.**

Equipment in use_____

Physician s Signature_____ Date:_____

**Return completed form in your next bill or to : Holmes-Wayne Electric Cooperative, Inc**
**Attn: Medical Awareness List**
**PO Box 112; Millersburg, Ohio 44654**