Medical Certificate Form

_____
CORE Member Name

_____
CORE Account #

_____
Patient Name

Is the patient the member or a permanent resident of the member's household?
☐ Yes
☐ No

_____ _____
CORE Account Holder Phone # CORE Member Email Address

Comments (Optional)
DO NOT include information regarding specific medical conditions.

This Medical Certificate Form and a letter must be sent to the utility from the office of a licensed physician or healthcare practitioner, which must include ALL of the following:

- The name of the individual whose illness is at issue.
- The Colorado medical identification number for the issuing physician or healthcare practitioner.
- Signature of the issuing physician or healthcare practitioner.
- Date
- The following statement: "**The disconnection of electric service will aggravate an existing medical condition or create a medical emergency for the patient.**" Information regarding specific medical conditions is **not** required.

Failure to meet the above requirements will delay the processing of this medical certificate.

Email this completed form and accompanying letter to **memberpayments@core.coop**, or send via mail to CORE Electric Cooperative, c/o Account Services, 5496 N. U.S. Highway 85, Sedalia, CO 80135.