

American Red Cross Identification Program Enrollment / Medical Certification Form

Name: _____
 Address: _____
 City, State and ZIP: _____
 County: _____
 Consumers Energy Account Number: _____

Home phone: () _____	Date of birth: _____
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Do you have backup equipment available? Yes No

Do you: live alone or live with someone who can provide needed assistance?

Are you independently mobile? <input type="checkbox"/> Yes <input type="checkbox"/> No, I use equipment for mobility (specify type): _____	Alternate contact person's Name: _____ Relationship: _____ Phone: () _____
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I hereby authorize Consumers Energy Company to furnish a copy of this form to the American Red Cross. I understand that I will be provided with information to help me prepare an emergency plan before an emergency happens. I also understand that participation in the program does not mean that my electricity will be restored faster and that the American Red Cross does not provide generators or transportation.

Signature _____

Date _____

PHYSICIAN'S CERTIFICATION – to be filled out by your physician

I certify that my patient _____, living at the above service address must use the following **electric** equipment _____ for treatment of _____.

I certify that this equipment is **medically necessary to support the life** of this patient.

Date life support added: _____

Physician's signature: _____

Printed name: _____ Phone: () _____

Address: _____