AMERICAN RED CROSS IDENTIFICATION PROGRAM

Enrollment/Certification

Name ______________________________ Date of Birth ______________

Address ______________________________

City ______________________ State ____________ ZIP Code ____________

County ______________________ Daytime Phone (   ) ______________

Consumers Energy Account Number ______________________________

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? ☐ Yes ☐ No, I use equipment for mobility - specify ____________

Alternate
Contact Name ______________________ Relationship ____________ Phone (   ) ____________

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 <u>does not</u> mean that my electricity will be restored faster and that the American Red Cross <u>does not</u> 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 ______________________________

City ______________________ State ____________ ZIP Code ____________

Mail completed form to: Consumers Energy
c/o Revenue Recovery
4000 Clay Ave SW, Room 214B
Grand Rapids, MI 49548-3017

or **FAX** to 517-325-8232