BLUE RIDGE ELECTRIC COOPERATIVE, INC.
SPECIAL NEEDS CERTIFICATION

Member Name:____

Member Account Number:____

Member Address:____

Member Telephone Number: ____

I hereby certify that termination of residential electric service to the above referenced member of Blue Ridge Electric Cooperative, Inc. would be dangerous to the health of the member or a person residing in the member's household at the premises to which electric service is rendered.

I understand that this certification expires one year from the date Blue Ridge Electric Cooperative receives this form.

Licensed Health Care Provider's Signature:____

Today's Date:____

Licensed Health Care Provider's Name:____
(Please print)

Licensed Health Care Provider's Address:____

Licensed Health Care Provider's Telephone Number:___________________________________

OFFICE USE ONLY
DATE RECEIVED:_____________________________SET UP BY:______________________