MEDICALLY ESSENTIAL SERVICE

In order for Florida Power & Light Company to determine whether a customer is eligible for designation as a Medically Essential Service ("MES"):

- Customer, Part A must be completed and signed by the Customer and the Patient or Guardian (if other than the Customer).
- Part B is to be completed by the Patient's physician and **the entire form consisting of both Part A and Part B** returned directly to FPL at the following address: FPL, Attn: Medically Essential Service Program CSF/GO, PO Box 029100, Miami, FL 33102-9100

Part A: CUSTOMER APPLICATION

FPL Account No: _____ Customer Name: _____

Service Address: _____

City _____ State _____ Zip: _____

Daytime Area Code & Telephone No: _____ and/or _____

Name of Person Using Equipment: _____

Patient's Physician: _____

To the best of my knowledge and belief, the Patient identified above is medically dependent on electric-powered equipment that must be operated continuously or as circumstances require as specified by the Patient's physician to avoid the loss of life or immediate hospitalization. The Patient is a permanent resident at the Service Address identified above. I agree to notify FPL when this equipment is no longer in use. FPL has fully explained how my account will be handled regarding any collection action due to non-payment of the bill**. I understand that FPL does not guarantee uninterrupted service or assign a priority status to my account for service restoration during outages. I understand that I must be prepared with backup medical equipment and/or power and a planned course of action in the event of prolonged outages**. I agree that FPL, upon request of federal, state, or local governmental authorities whose duties or functions include emergency response or disaster relief or prevention, or private entities authorized by congressional charter to assist in disaster relief efforts, may disclose to such requesting entity the following MES information: the MES Customer name and service address. However, I also understand that FPL may not receive any such requests for this MES information and that FPL has no obligation to release this MES information to any such entity. In order to be excluded from the disclosure by FPL of the MES information on this form, I must contact FPL to request a Notice of Exclusion From Disclosure. The Notice of Exclusion From Disclosure must be returned to FPL, as provided with the Notice of Exclusion From Disclosure, and will be effective upon FPL's receipt of such properly completed Notice. If I wish to ensure that the MES and/or any additional information regarding the Patient's condition is furnished to any such entity, I will contact the relevant authorities and provide the MES and/or additional information myself. **I agree to hold FPL harmless from any claim based on or related to the disclosure of my information by or to FPL, or any failure of FPL to disclose the MES information whether advertent or inadvertent and whether or not the MES information was requested.**

_____ **Date:** _____**,20**_____

Customer Signature

_____ **Date:** _____**,20**_____

Patient's or Guardian's Signature {if other than the Customer)

WARNING - PART A - CUSTOMER APPLICATION: Knowingly making a false or misleading statement in completing the Customer Application could result in the denial or termination of the medically essential service certification.

Part B: PHYSICIAN'S CERTIFICATE

Physician's Name: _____ **Physician's License#:** _____

Physician's Address: _____

Physician's Area Code & Telephone No: _____ and/or _____

I, _____, duly licensed and authorized to practice medicine in the State of Florida,
(Name of physician)

hereby certify that_____ who resides at _____
(Name of Patient) (Patient's place of residence)

is under my care, has been seen by and/or has consulted with me within the past 12 months, and depends upon electric-powered equipment that must be operated continuously or as circumstances require as specified below in order to avoid the loss of his/her life or serious medical complications requiring his/her immediate hospitalization. The medically essential equipment upon which this patient relies and is described as follows: **Required**:_____

_____

The patient uses this equipment (___) **hours** within each twenty-four (24) hour period. The following **medical condition** is why, in my opinion, this patient needs the continuous or specified use of this equipment in order to avoid the loss of his/her life or serious medical complications requiring his/her immediate hospitalization: *[Attach additional pages if necessary]:* **Required:**_____

_____

_____

_____

Physician Signature_____ **Date:** _____**,20**_____

WARNING - PART B - PHYSICIAN'S CERTIFICATE: False certification of medically essential service by a physician is a violation of *s. 458.3311(1)(h)* or s. *459.015 1)(i), Fla. Stat.* and constitutes grounds for discipline, penalties and/or enforcement.

All fields included in this certificate are required to be completed to be deemed eligible for review. If the certificate is deemed valid, it shall be for a period of twelve (12) months from the date the certificate is accepted by FPL for purposes of determining that a customer qualifies as a Medically Essential Service Customer within the meaning of Section 1.65 of the Company's General Rules and Regulations for Electric Service, or that such designation should be renewed. FPL reserves the right to verify the accuracy of the information provided on this Physician's Certificate.

Please note if any of the fields are left blank, it will cause a delay in the processing of the Medically Essential Service Program application.