Consumers Energy
Count on Us®

AMERICAN RED CROSS IDENTIFICATION PROGRAM

Enrollment/Certification

Name _____ Date of Birth _____

Address _____

City _____ State MI 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 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 _____

City _____ State _____ ZIP Code _____

Mail completed form to: American Red Cross
5640 Venture Ct.
Kalamazoo, MI 49009