Exhibit 24-1A

EIEC MEDICAL EQUIPMENT REGISTRY ENROLLMENT FORM

The purpose of this form is to assist members in registering electrically powered medical equipment. Eastern Illini Electric Cooperative (EIEC) cannot guarantee uninterrupted service, but it will make its best effort to restore power outages on a priority basis.

MEMBER INFORMATION (to be completed by member)

NAME OF INDIVIDUAL REQUIRING MEDICAL EQUIPMENT _____

ADDRESS _____
Street, Box No. City State Zip

I authorize EIEC to contact any of the below named parties and I authorize the named parties to release any necessary information regarding medical equipment and need for such equipment.

X _____ PHONE _____
MEMBER'S SIGNATURE

(MEMBER'S ADDRESS IF DIFFERENT FROM ABOVE)

_____
Street, Box No. City State Zip

NAME, ADDRESS AND PHONE NUMBER OF THIRD PARTY WHO CAN BE NOTIFIED IN THE EVENT OF AN EMERGENCY

Phone (_____) _____ - _____

_____
Name Street, Box No. City State Zip

PHYSICIAN'S STATEMENT (to be completed by attending physician)

NAME OF PHYSICIAN _____

ADDRESS _____
Street, Box No. City State Zip

PHONE (_____) _____ - _____

HOSPITAL AFFILIATION _____

PATIENT'S DIAGNOSIS _____

(over)

TYPE OF MEDICAL EQUIPMENT:

A. Respirator	____	B. Oxygen Monitor/Pump	____	C. Heart Monitor	_____
D. Lung Monitor	____	E. Nebulizer	____	F. Kidney Dialysis	_____
G. Apnea Monitor	____	H. Other_____			

How often is the equipment used? _____

How long is the equipment used for each treatment? _____

How long can the patient be without the equipment? _____

Is there a source of standby power for the equipment? Yes_____ No_____

Is the equipment portable? Yes_____ No_____

Is there an alternate equipment available? Yes_____ No_____

If yes, please explain _____

How long can the alternate equipment be used?
_____

Based upon your diagnosis of the above individual, please select <u>one</u> of the following:

_____ CRITICAL CARE: *Daily and continuous use of electrical medical equipment 24 hours a day.* Will receive highest possible priority and will have service restored as quickly as possible.

_____ CAUTIONARY CARE: *Intermittent use of electrical medical equipment.* Will receive priority and will have service restored as soon as possible.

Physician's Signature _____

Date _____/_____/

Please return to: Eastern Illini Electric Cooperative
P. O. Box 96, Paxton, IL 60957
FAX # 217-379-2936
1-800-824-5102

Account #