Critical Care

Customer Application

IMPORTANT NOTICE: Acceptance into the "Critical Care" program **does NOT guarantee** continuous electrical service. If continuous power is required for life support or other vital condition, alternative arrangements should be made to ensure backup power is available in the event of power interruption.

TO BE FILLED IN BY CUSTOMER

Customer Name: ______________________________ Account Number: ______________________________

Street Address: ______________________________ City, State, Zip: ______________________________

Patient's Name: ______________________________ Physician's Name: ______________________________

Home Phone: ____________ Work/Other Phone: ________________ Physician's Phone: ____________

Authorization: I hereby authorize release of any medical information that is pertinent to my qualifying as a medical customer with the City of Independence Power & Light Department. By signing below, applicant acknowledges the accuracy and truth of the information provided.

Signature of Patient or Legal Guardian: ____ Date: ______________

TO BE FILLED IN BY PHYSICIAN (please print legibly)

Please describe the nature of ailment: ____

Is patient bedfast? ❑ Yes ❑ No

Is continuous use of the electric equipment necessary for critical medical reasons? ❑ Yes ❑ No

If yes, what type of equipment: ____

Is there backup equipment installed in case of electric interruption? ❑ Yes ❑ No

Is the patient's condition temporary? ❑ Yes ❑ No

If yes, estimated time period when condition would warrant the removal from critical customer list: ______________

Additional Comments: ____

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Physician's Name **(please print)**	Physician's Signature:	
Office Address:	City, State, Zip	Date:

Please mail to: **Customer Service, City of Independence, P. O. Box 1019, Independence, MO 64051-0519**

TO BE FILLED IN BY CUSTOMER SERVICE – CITY OF INDEPENDENCE

❑ Approved
❑ Rejected By: ____ Date: ______________