



Date Sent: _____
Please retain copy in file(s)

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: _____

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: _____