Date Sent: _____

Please retain copy in file

Critical Care
Customer Application

IMPORTANT NOTICE: **Acceptance into the Critical Care program does not guarantee continuous electrical service, or shield customers from disconnection for non-payment of utility bills.** If continuous power is required for life support or other vital conditions, 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: _____ 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

What type of equipment? (i.e. oxygen concentrator, CPAP, nebulizer, respirator, etc.)

Is there backup equipment installed in case of electrical interruption? □ Yes □ No

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

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

Additional Comments: _____

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

Please mail to: **City of Independence Utilities, Customer Service, PO Box 410, Independence, MO 64051**

TO BE FILLED IN BY CUSTOMER SERVICE - CITY OF INDEPENDENCE

□ Approved

□ Not Approved Signature: _____ Date: _____