

**Critical Customer Care Program  
 Customer Application and Certification**

**New**                       **Re-verification**

**CUSTOMER STATEMENT**

**Customer of Record:** \_\_\_\_\_

**Account Number:** \_\_\_\_\_

**Street Address:**  
**No.:** \_\_\_\_\_

**Phone** \_\_\_\_\_

**Name of Patient:** \_\_\_\_\_ **Social Security No.:** \_\_\_\_\_

**Is the Patient a permanent resident of the household?**     **Yes**     **No**

**Relationship of Patient to Customer of Record:** \_\_\_\_\_

As customer of record, I understand and agree that participation in the Critical Customer Care Program does not guarantee that electrical service interruptions will not occur. It is my responsibility as the customer to plan for these outages by arranging for an alternate power source or backup generator, as well as a plan for evacuation to another location. In addition, this situation has been reviewed with the physician, and I understand the physician's recommendation for the medical conditions in the event that interruption in electrical service should occur.

**Customer Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PHYSICIAN CERTIFICATION (To be completed by a licensed physician)**

Your patient named above has made application to the Critical Customer Care Program. This application must include physician information to verify the nature of the patient's medical condition and/or the use of life support equipment at the address shown above. Eligibility for this program must be renewed no less than annually. Eligibility may be required more frequently, depending on the condition or expected duration of use.

**Critical Customer Care Program:** The Critical Customer Care Program helps customers prepare for planned and unplanned power outages for whom a service interruption could be immediately life threatening or would make operation of necessary medical or life supporting equipment impossible or impractical.

**Please provide the following information pertinent to your patient and this program.**

**Primary Medical Conditions:** \_\_\_\_\_  
 \_\_\_\_\_

**Secondary Contributory Conditions:** \_\_\_\_\_

**Medical or Life Support Equipment:** \_\_\_\_\_ **Duration of Use:** \_\_\_\_\_

**Based on review of the above information, it is my professional opinion that this patient is medically eligible for the Critical Customer Care Program.**

I have reviewed my recommendations with the patient or patient representative and discussed needs for an alternate power source, backup generator, or a plan for evacuation to another location.

**Physician Signature:** \_\_\_\_\_ **M.D., D.O.**

**Physician Name (Please Print):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_ **Phone No.:** \_\_\_\_\_

**COMPANY REVIEW/APPROVAL**

**Customer Application Completed?**     **Yes**     **No**                      **Physician Recommendation Reviewed?**     **Yes**     **No**

**Administrative Approval Granted for Critical Customer Care Program?**     **Yes**     **No**

**Additional Information or Follow-Up Plan:** \_\_\_\_\_

**Company Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_