CRITICAL CARE INFORMATION Date: ____________________________

TO BE COMPLETED BY NBU

Name on Account: ____
Account Number: ____
Service Address (that patient resides in): ____

TO BE COMPLETED BY CUSTOMER

Customer Information

Name on Account: ____
Patient Name (please print): ____
Telephone Number (including Area Code): Home ____________________ Work ______________________
Service Address that patient resides in: ____
Secondary Contact Name: ____
Relationship: ____
Telephone Number for Secondary Contact (including Area Code):
Home ______________________________ Work ___________________________
Patient's Signature: ____ Date: _______________________

TO BE COMPLETED BY PHYSICIAN

Physician Information

Physician Name: ____
Physician Address: ____
Physician Telephone Number: ____

Medical Equipment Information

Type of Electric, Life Sustaining Equipment Used:
____

Medical Diagnosis: ____
Does customer require on-site back-up capabilities or other alternatives for loss of normal electrical service?
(*please mark one*) Yes ☐ No ☐
If yes, please describe: ____
How long can a patient sustain without electrical service? (*number of hours*) ____________________________
Is condition life threatening without electrical service? (*please mark one*) Yes ☐ No ☐
Physician's Signature: ____ Date: ________________________

This qualification requires renewal one year from the date you are qualified. The information on this form may be subject to verification and additional information may be required from you or your physician.

Qualification pursuant to this form does not guarantee an uninterrupted power supply, and if electricity is a necessity, you may need to make other arrangements.