

CITY OF MARTINSVILLE ELECTRIC POWER LIFE SUPPORT DEVICE VERIFICATION

ATTENDING PHYSICIAN STATEMENT

This is to confirm that a Life Support (Life Sustaining) Device is presently used by:

Patient Name: _____

Address: _____

Patient is: Minor _____ over the yrs of age 65 _____ N/A _____

Type of Life Support Equipment: _____

Requires electricity of operate? Yes _____ No _____

How long can equipment be inoperative without being life threatening to the patient? _____

Does device have an emergency power supply? Yes _____ No _____

The need for this equipment is: Short Term _____ Long Term _____

Physician Signature: _____

Physician (Print Name): _____

Address: _____

Office Telephone Number: _____

CUSTOMER STATEMENT

I agree that the information provided is accurate. I understand that this information must be verified and provided to the City of Martinsville Electric Department each year. When the equipment is no longer needed, I will notify the City Electric Department to update my account and discontinue requests for annual verification.

I understand that the City Electric Department cannot guarantee electric service and it is my responsibility to maintain a back-up system or have an alternate plan in the event of power loss.

Customer Signature: _____

Or

Third Party Contact: _____

Telephone Number: _____ Date: _____

OFFICE USE ONLY:

Customer Name: _____ Account No: _____

Customer Address _____ Circuit No: _____

Transformer Pole No: _____ Service Pole No: _____