Life Support Registry

Completion by Customer **PLEASE PRINT**

LEC Member Name: ____________________________ Account # _______________
Patient Name: _____________________________________
Telephone Numbers: Home _______________________ Work ___________________
Secondary Contact Name: ____
Relationship: ___________________________________ Phone # _________________

Non-payment of electric bill within 30 days of billing will result in termination of service, regardless of being registered as a priority list customer.

Patient or Guardian Signature: ______________________________ Date: ____________

Completion by Patient's Physician **PLEASE PRINT**

Physician Name: ____
Physician Address: ____
Physician Phone Number: ____

Medical Equipment Information

Type of electric, life sustaining equipment used: _______________________________
Medical diagnosis: ____
Does customer require on-site backup capabilities or other alternatives for loss of normal electric service? _____ Yes _____ No
If yes, please describe: ____
How long can patient sustain without electrical service? (Number of Hours) __________
Is condition life-threatening without electrical service: _____ 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.

Do you have a backup generator? _____ Yes _____ No