Prairie Land Electric Cooperative Inc
PO Box 360
Norton, KS 67654
(800) 577-3323

Application for classification as a

LIFE SUPPORT / CRITICAL NEEDS CUSTOMER

If accepted, a renewal application will be sent annually. Acceptance does not guarantee uninterrupted electrical service, does not give priority restoration in an outage, and does not prevent collection activity for unpaid electric bills. If electric service is critical for life support, it is your responsibility to arrange for private back-up power systems where appropriate, and develop alternative care plans to ensure safety and security during power interruptions. Contact your physician for other alternatives. The Life Support / Critical Needs program is intended only for customers who are on a life-support system and unable to readily leave the home.

TO BE COMPLETED BY CUSTOMER-PLEASE PRINT

______________________ Customers Name On Prairie Land Electric Acct. ______________ Account Number ______________ Home Phone

______________________ Street Address ________ City & State ______ Zip Code ________ Work Phone ________ Cell Phone

______________________ Name of Secondary Contact -Required ________ Home Phone ________ Work Phone ________ Cell Phone

______________________ Patient's Name ________ Birth Date

<u>For your protection the law requires you to be advised:</u> It is a criminal act to make false or fraudulent claim, or assist in the preparation or presentation of a false or fraudulent claim. Violators of this provision may be subject to criminal prosecution.
<u>Authorization:</u> I hereby authorize release of any medical information, including direct consultation with any physician that is pertinent to my qualifying as a Life Support/Critical Needs Customer with Prairie Land Electric COOP, Inc.
By signing below, I acknowledge the accuracy and truth of the information provided.

______________________ Name of Patient or Legal Guardian (Please Print) ______________________ Signature of Patient or Legal Guardian ________ Date

TO BE COMPLETED BY PHYSICIAN-PLEASE PRINT

Is electrically-powered medical equipment required to sustain life? YES _______ NO _______

If YES, What type of equipment? ____

Is the patient homebound? YES_______ NO________

Nature of Ailment ____

Is the medical equipment capable of being operated by battery-supplied electricity? YES________ NO________

How often is the medical equipment used? ____

Is the patient's condition temporary? YES________NO________ If YES, when will condition warrant removal from

Life Support/Critical Needs Customer list? ____

Note: Where necessary, it is important that you advise your patient of the appropriate precautions measures and the emergency actions to take in case there is a power outage or his or her medical equipment fails to operate for any other reason.

Additional Comments: ____

______________________ Physician's Name (Please Print) ______________________ Office Address ______________________ Phone

______________________ Physician's Signature ______________________ City, State, Zip Code ______________________ Date