



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

For your protection the law requires you to be advised: 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.

Authorization: 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