



**EAST GRAND FORKS WATER AND LIGHT DEPARTMENT
MEDICAL LIFE SUPPORT PROGRAM ENROLLMENT FORM**

This enrollment form is to be completed by the customer of record and a registered attending physician. Once enrolled, East Grand Forks Water and Light will attempt notification prior to scheduled interruptions in electric service for the area due to repair, upgrades to our system, etc. Completion of this form does NOT prevent disconnection for non-payment. If the individual using life-support equipment cannot be without power for any reason, East Grand Forks Water and Light recommends developing alternate plans. Please consult with your physician and/or medical equipment supplier regarding your particular medical needs.

East Grand Forks Water and Light exercises reasonable diligence in supplying continuous electric services. Under no circumstances is the company a guarantor or insurer of uninterruptible service. For example, there are numerous situations where conditions beyond our control can result in power outages. All service is restored following an interruption as soon as practical. East Grand Forks Water and Light will not be liable for any injury, loss or damage resulting from interruption, shortage or insufficiency of service or irregularities of service.

Resident agrees to notify East Grand Forks Water and Light if the individual named below is no longer on life support at the address listed below or has moved to a different location, either within our outside the East Grand Forks Water and Light service area.

TO BE COMPLETED BY CUSTOMER:

Water & Light Account Number: _____ Name on Water & Light Account: _____

Name of Patient: _____ Relationship to Customer of Record: _____

Street Address: _____ East Grand Forks, Phone Number: _____

Emergency Contact Name: _____ Emergency Contact Phone Number: _____
(person NOT resident at the residence)

Does patient have backup generation equipment available? Yes No

Does patient (check one): Live alone Live with someone who can provide needed assistance?

Customer Signature: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN:

Physician Name: _____

Address: _____
Street/PO Box City State Zip Code

Physician Phone Number: _____

Type of Life Support Equipment: _____

Is the equipment expected to be needed (check one): Short Term (less than 6 months) Long Term

I acknowledge that the patient listed above requires life-support equipment that is medically necessary to support the life of this patient.

Physician's Signature: _____ Date: _____