MEDICAL PRIORITY CUSTOMER APPLICATION

CUSTOMER'S NAME _____ ***ACCOUNT #***_____

CUSTOMER'S ADDRESS _____

HOME PHONE _____ ***BUSINESS PHONE*** _____

PATIENT'S NAME_____ ***RELATIONSHIP*** _____
(IF OTHER THAN CUSTOMER)

I hereby request to be placed on the Public Works Commission's Medical Priority Customer List. I understand that being placed on this listing applies only to the reestablishment of service in the event of a power outage at my service location. I also understand that by being placed on the Medical Priority List, I am authorizing PWC to enroll me in the free Interactive Voice Response program whereby I will receive an automated phone call if my payment is not received by the due date.

Also, I am authorizing my physician to release any information, records, or provide PWC with a statement of my medical condition that would qualify me for this service. All records will be held in confidence by this office.

CUSTOMER'S SIGNATURE_____ ***DATE*** _____

PHYSICIAN USE ONLY

PLEASE PRINT CLEARLY.

Patient's Name_____

DOB_____ ***SSN#*** _____

How long have you been this patient's physician of record? _____

Detailed description of the above patient's health problem(s), present condition, and prognosis:

_____

_____

_____

What type of electrically operated life support equipment does this patient use at home?

Tank-type respirator (iron lung)	_____
Curaisse-type chest respirator	_____
Intermittent positive pressure respirator	_____
Oxygen concentrator	_____
Hemodialysis equipment	_____
Intravenous pump	_____
Suction machine	_____
Nebulizer	_____
Heart and/or breathing monitor	_____
Heart and/or breathing monitor	_____
Feeding device	_____

Other (please specify) _____

How often must the patient use this equipment in order to avoid life-threatening conditions?

Continuously	_____
At least a portion of every day	_____
Less than once a day on average	_____

What type of back-up equipment does this patient have to sustain life in the event of an electric service outage (include portable equipment that may enable patient to be mobile)?

_____

Will this equipment operate continuously for more than 8 hours without being plugged in?

Yes _____ ***No*** _____

Is this patient ambulatory?	***Yes*** _____	***No*** _____
Able to leave home unassisted?	***Yes*** _____	***No*** _____
Able to operate an automobile?	***Yes*** _____	***No*** _____

How long could this patient function without electricity or backup equipment without his/her survival being threatened?

_____

_____

PHYSICIAN'S NAME_____ ***BUSINESS PHONE*** _____

PHYSICIAN'S ADDRESS_____

PHYSICIAN'S SIGNATURE_____***DATE***_____

RETURN TO:

PUBLIC WORKS COMMISSION
ATTN: CUSTOMER SERVICE DEPT.
PO BOX 1089
FAYETTVEILLE, NC 28303-1089

TELEPHONE (910) 223-4204
FAX (910) 483-5402
