Print Form

MVEC
Magic Valley Electric Cooperative
Your Touchstone Energy® Partner
The power of human connections®

LIFE SUPPORT SYSTEM REQUEST FORM

DATE:_____

MEMBER INFORMATION

MEMBER'S NAME:_____ **ACCOUNT #:**_____

PATIENT'S NAME(IF NOT THE SAME AS ABOVE):_____

MAILING ADDRESS:_____ **CITY/STATE/ZIPCODE:**_____

CONTACT INFORMATION

HOME TELEPHONE #:_____ **WORK TELEPHONE #:**_____

NAME OF NEAREST RELATIVE:_____ **TELEPHONE #:**_____

Is there back-up power or alternate equipment available? ☐ **YES** ☐ **NO**

_____ _____

Member's Signature **Date**

PHYSICIAN'S INFORMATION (*Please answer the following questions)*

1. **Brief description of type of life support required:**_____
2. **Will equipment operate without electric service?** ☐ **YES** ☐ **NO**
   If yes, how long?_____
3. **Is there back-up power or alternate equipment available** ☐ **YES** ☐ **NO**
4. **Notice requested prior to disconnect?** ☐ **YES** ☐ **NO**
5. **Will the disconnection of electric service be detrimental patients health?** ☐ **YES** ☐ **NO**
6. **As of this date is life support equipment in service and required?** ☐ **YES** ☐ **NO**

I certify that the above named patient is under my care and requires the life support equipment listed above.

Physician's Name (PRINT):_____ **Telephone #:**_____

Physician's Signature:_____ **Date:**_____

Office Use Only: Billing Book #_____ Cycle#: _____ Entered By:_____ Date Entered:_____