MAYERTHORPE & DISTRICT RURAL ELECTRIFICATION ASSOCIATION LTD
c/o Rocky R.E.A.
PO Box 1538, Rocky Mountain House, AB T4T 1B2
Phone: 1-888-845-4616
Fax: (403) 845-2751 Email: sskaalerud@rockyrea.com

CRITICAL CARE STATUS APPLICATION

Account Number:_____ **Account Name:**_____

Land Location:_____ **Site ID:**_____

Mailing Address:_____

Name of Critical Care Patient (if different than account name) _____

Contact Information:

Telephone Numbers:

Residential: _____ **Business:** _____

Cell: _____ **Email:** _____

Emergency Contact Information:

Name: _____

Relationship to patient: _____

Telephone Numbers: _____ **Alternate:**_____

**** Emergency contact information must be filled out or insert "I choose not to provide an emergency contact name".**

NOTE:

- ***With regard to a pre-planned power outage, the REA will attempt to contact in advance so that you can make arrangements for transport to another location, if necessary. However, because of the wide variety of circumstances under which (unplanned) power outages occur, the REA cannot guarantee notification or restoration time.***
- ***If you have critically important medical equipment that requires electric power to operate, you should have a back-up source of power available at your residence.***
- ***Submission of this application does not automatically result in critical care status.***
- ***Designation as a critical care customer does not relieve a customer of the obligation to pay for electric service and service may be disconnected for failure to pay. All applicable reconnection fees will apply.***

CUSTOMER:

I have read and understood the information and certify that the information provided on this application is correct. I understand the information may also be used to provide notices relating to my electric service to the Emergency Contact.
I certify that the patient lives at the address listed above and that all information provided is accurate.
I hereby authorize my physician to release the following information about the above named patient to the REA to determine if the identified medical conditions meets the definition of a serious medical condition.

Signature: _____ **Date:** _____

PATIENT/PATIENT'S GUARDIAN, PARENT, OR MANAGING CONSERVATOR:

I have read and understood the information and certify that the information provided in this application about me (or the patient) is correct. I agree to the release of the information on this form concerning my (or the patient's) medical condition for the purposes stated on this application.

Signature: _____ **Date:** _____

(signature required, even if same person as Customer)

TO BE COMPLETED BY PHYSICIAN AND MAILED IN OR EMAILED BY PHYSICIAN*:*

Patient's Name: _____

The patient is dependent upon an electric-powered medical device to sustain life. Yes _____ No____

The patient has a serious medical condition that requires an electric-powered medical device or electric heating or cooling to prevent impairment of a major life function through a significant deterioration or exacerbation of the person's medical condition. Yes _____ No____

Name of Physician: _____

Name of Medical Facility at which Physician Practices and Mailing address: _____

_____

Physician Phone Number: _____

Physician Signature: _____**Date:** _____