



**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?*

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*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**

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