



Office Use Only \_\_\_\_\_ Date Received \_\_\_\_\_

Avista Utilities is committed to working with customers using electrical medical equipment in their homes. Although we cannot guarantee that electric service will not be interrupted by a storm, an accident, or by unforeseen equipment failure, we will make every effort to supply your household with safe and reliable electric service.

If you have not done so, you should make provisions for a secondary source of power for your medical equipment, be it mechanical or a change of location such as a hospital which would have its own on-site generation.

Customer Information			
Name		Account Number	
Address	City	State	Zip Code
Day Phone		Mobile Phone	
Name of Individual Using Medical Equipment	Date of Birth	Relationship to Customer of Record	
Emergency Contact Name		Emergency Contact Phone	
Equipment Supplier		Supplier Phone	

**Customer Authorization:**

I agree to notify Avista Utilities when the equipment is no longer in use.

I hereby grant Avista Utilities the authority to release or obtain information to/from a third party(ies).

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Please Have Your Physician Complete the Following Information**

Doctor's Name		Title/Specialty	
Organization		Phone	
Address	City	State	Zip Code
What type of electronic medical equipment is used in this home?			
Is the unit portable? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is there battery backup to this unit? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the prescribed number of hours per for use of the equipment?			
What is the projected length of time this patient will require this medical equipment?			
If an oxygen concentrator, does the patient have liquid backup? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Additional Comments			

I certify the information I have provided is correct.

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

Please Have Physician's Office Return Form to Fax Number: 1 (866) 458-5710