## San Bernard Electric Cooperative, Inc.

APPLICATION for Chronic Condition or Critical Care Residential Customer Status

<table>
<tr><td colspan="4">All Information is required.</td></tr>
<tr><td colspan="4">PART 1 – TO BE COMPLETED BY THE CUSTOMER</td></tr>
<tr><td>Member Name<br>(person's name on electric account)</td><td></td><td colspan="2"></td></tr>
<tr><td>Service Address<br>(physical 911 Address)</td><td></td><td>City, State, Zip</td><td></td></tr>
<tr><td>San Bernard Account Number (found on bill)</td><td colspan="3"></td></tr>
<tr><td>Mailing Address<br>(if different than the Service Address)</td><td></td><td>City, State, Zip</td><td></td></tr>
<tr><td>Primary Phone Number</td><td></td><td>Cell Phone Number</td><td></td></tr>
<tr><td colspan="2">Secondary Contact Name<br>(Person other than yourself listed on the account or someone who you authorize to be contacted about your electrical service.)</td><td colspan="2"></td></tr>
<tr><td colspan="2">Phone Number of other Contact</td><td colspan="2"></td></tr>
<tr><td colspan="4">I have read and understood the preceding information and certify that the information provided in this form is correct.<br>Member Signature Date</td></tr>
<tr><td colspan="4">Patient's Name ____________________________________Relation to Member______________<br>(Person, <u>residing permanently at the above Service Address,</u> for whom critical care or chronic condition status is being sought).</td></tr>
<tr><td colspan="4">I have read and understood the preceding information and certify that the information provided in this form about me (or the patient) is correct. I consent to the release of the information in this form concerning my (or the patient's) medical condition for the purposes stated in this form and in processing this form.<br>Patient/Patient's Guardian, Parent, or Managing Conservator Signature Date</td></tr>
</table>

<table>
<tr><td colspan="4">PART 2 – TO BE COMPLETED BY PATIENTS PHYSICIAN</td></tr>
<tr><td colspan="2">Medical Condition(COPD,Dialysis,etc)</td><td>YES</td><td>NO</td></tr>
<tr><td colspan="2">The patient is dependent upon an electric-powered medical device <u>to sustain life.</u></td><td></td><td></td></tr>
<tr><td colspan="2">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.</td><td></td><td></td></tr>
<tr><td colspan="2">The above medical condition <u>has</u> been diagnosed as a life-long condition.</td><td></td><td></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Physician Name<br>(Printed)</td><td></td><td>Medical Agency</td><td></td></tr>
<tr><td>Telephone Number</td><td></td><td>Fax Number</td><td></td></tr>
<tr><td colspan="4">Medical or<br>Physician Signature Date</td></tr>
</table>