LEXINGTON ELECTRIC SYSTEM NECESSITY FORM FOR LIFE SUSTAINING ALTERNATING CURRENT ELECTRICAL DEVICES

Patients Name: ______________________________ Patients Address: _________________________________

(Please Print Patients Name)

PATIENT MEDICAL AUTHORIZATION

By my signature below, I hereby authorize my physician or nurse practitioner to furnish to Lexington Electric System, 92 South Main Street, Lexington, Tennessee 38351, the information requested below. I also waive all privileges and confidentiality which may exist in the doctor/patient relationship so as to permit the release of all information required by Lexington Electric System. I further release my physician or nurse practitioner and Lexington Electric System from all claims that I have or may claim to have for invasion of privacy or providing information protected under the HIPPPA Privacy Standards. I further agree to hold Lexington Electric System harmless from any claims and damages for injury or death resulting from or related to termination of electrical service at the address shown above should payment for past due bills not be made in full within three days of Lexington Electric System's delivery of notice that Customer's electric account is past due and subject to termination.

Date: ___________________ Patient or Legal Guardian Signature: _____________________________

CUSTOMER'S ACKNOWLEDGEMENT

I have been informed by Lexington Electric System that submittal of this form will not release me from my responsibility for paying my electric bill and any service fees in full. I agree to hold Lexington Electric System harmless from any claims and damages to property and for injury or death resulting from or related to termination of electrical service at the address shown above should payment for past due bills not be made in full. I acknowledge that it is my responsibility to arrange for the transfer of the above named patient to another location in the event that I cannot make payment in full within three days of Lexington Electric System's delivery of notice that my electric account is past due and subject to termination.

Date: _________________________ Customer Name: ____

(Please Print Customer Name)

Phone No: _____________________ Customer Signature: ____

PHYSICIAN: PLEASE CAREFULLY READ AND COMPLETE ALL QUESTIONS IN THIS SECTION

This section of the certification can only be completed by a medical doctor or nurse practitioner, and is applicable only for the use of alternating current electrical devices required to sustain life. This form should not be certified when applicable to the use of battery powered direct current devices, or simply for the personal comfort or convenience of the patient. The completed form must be faxed from the physician's office to Lexington Electric System at 731-968-8988, or emailed from the physician's office to Lexington Electric System at mrhodes@lexingtonelectric.com

I am a physician/nurse practitioner (circle one) licensed in the State of _________________. The above named person is a patient of mine and is presently under my care and treatment. The above named patient is suffering from a medical condition that requires that patient to use the following life-sustaining alternating current electrical devices(s) or equipment.

Type of Device or Equipment: ____

In my opinion, the termination of electrical service at the present time would result in an immediate life-threatening condition for the above named patient. My opinion is based upon my reasonable degree of medical certainty.

Date: ______________________________ Physician Name: ____

(Please Print Physician Name)

Phone No: __________________________ Physician Signature: ____

The information below is to be completed by Lexington Electric System