MISSION VALLEY POWER
LIFE SUPPORT or SPECIAL MEDICAL EQUIPMENT

The form is needed by Mission Valley Power (MVP) to assist us in identifying customers in need of medical equipment requiring electricity. The information provided will "flag" the customer in the event of a planned power outage, especially if the outage is for more than 2 hours in duration.

MVP cannot guarantee power will always be on. Maintenance and unforeseen outages will and do occur occasionally. If you have questions call 406-883-7900.

Thanks in advance for completing this information.

THE FOLLOWING IS TO BE COMPLETED BY THE CUSTOMER OF RECORD

This is to certify that _____ is a permanent resident of:
(print full name of patient)

Mission Valley Power account number _____

Name on MVP account (please print) _____

Street Address: _____

City, Zip, State: _____

Telephone Number: _____

Customer's signature _____

Date _____

If Customer is on Oxygen, do you have back up source? _____ How long? _____

THE FOLLOWING TO BE COMPLETED BY A REPRESENTATIVE OF
MISSION VALLEY POWER

Mission Valley Power location number _____

Pole number _____

Meter number _____

To be completed by a licensed physician *yearly* and returned to Mission Valley Power, PO Box 97, Pablo, MT 59855. It may be faxed to 406-883-7919.

Dear Physician:

The completion of this form is to be done by you only after you have personally examined the individual whose name appears hereon.

I have examined _____(the "Patient") whose
(print full name of patient)
Permanent residence address is _____

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1. **Certification of Necessary Life-supporting Equipment**
   I certify that the Patient is required to operate the following life-supporting equipment:
   _____

   from _____, 20___, to _____, 20___, with the following frequency: _____, and that disconnection of electric service to the Patient's residence would render the operation of the above equipment impossible or impractical because: the equipment is not readily portable; the equipment cannot be operated manually or with another power source such as batteries; substitute equipment that does not require electric service to operate is not available; or _____.
   (other)
2. **Certification of Special Medical Equipment**
   I certify that the Patient is required to operate the following medical equipment:
   _____

   From _____, 20___, to _____, 20___, with the following frequency: _____. This equipment is not life threatening if the power was disconnected.

Dated: _____ _____
(print full name of physician)

_____
(physician's signature)

_____
(Office Telephone)

Updated 4/2013