TO VERIFIERS OF UTILITY CUSTOMERS HAVING LIFE-THREATENING CONDITIONS

THE OKLAHOMA CORPORATION COMMISSIONS REQUIRES ELECTRIC AND GAS UTILITIES UNDER ITS JURISDICTION TO HONOR CERTIFICATES WHICH ATTEST TO THE FACT THAT A UTILITY CUSTOMER OR A PERMANENT MEMBER OF THE HOUSEHOLD HAS A MEDICAL CONDITION WHICH PLACES HIS/HER LIFE IN JEOPARDY, AND WHICH WOULD BE FURTHER AGGRAVATED BY THE DISCONTINUANCE OF THE AFOREMENTIONED UTILITY SERVICES. THE RESPECTIVE CUSTOMER MAY CERTIFY THE CONDITION FOR 72 HOURS BUT FURTHER VERIFICATION OF THE CONDITION IS REQUIRED IF IT PERSISTS BEYOND A 72 HOUR PERIOD. VERIFICATION MAY BE BY A PHYSICIAN, LICENSED PRACTITIONER OF THE HEALING ARTS, PUBLIC HEALTH OFFICIAL, OR A GOVERNMENT SOCIAL SERVICE OFFICIAL. SUCH VERIFICATION IS VALID FOR 30 DAYS AND MUST BE RENEWED OR REVERIFIED EVERY 30 DAYS. YOU ARE BEING ASKED TO PROVIDE VERIFICATION THAT THE STATED CONDITION STILL EXISTS AND WILL CONTINUE TO EXIST FOR THE NEXT 30 DAYS.

PLEASE BE ADVISED THAT YOUR ACTIONS IN THIS MATTER MAY RESULT IN THIS PERSON BEING PERMITTED TO USE UTILITY SERVICES WITHOUT IMMEDIATE PAYMENT IF THEIR FINANCIAL CONDITION SO WARRANTS. HOWEVER, FULL RESTITUTION IS REQUIRED WHEN THE "LIFE-THREATENING" CONDITIONS CEASE TO EXIST.

WE APPRECIATE YOUR WILLINGNESS TO PARTICIPATE AS VERIFIER AND TRUST YOU WILL DO SO ADVISEDLY CONSIDERING THE FACT THAT ENERGY CONSUMED DURING THIS PERIOD MUST EVENTUALLY BE PAID FOR BY THE UTILITY CUSTOMER.

WE WANT TO ASSURE THAT THOSE UTILITY CUSTOMERS HAVING A GENUINE LIFE-THREATENING CONDITION IN THEIR HOMES ARE NOT MISTAKEN FOR THOSE WHO WOULD ABUSE THIS PRIVILEGE AT THE EXPENSE OF OTHER RATEPAYERS.

ATTENDING PHYSICIAN STATEMENT

THIS IS TO CONFIRM THAT A LIFE SUPPORT (LIFE SUSTAINING) DEVICE IS PRESENTLY USED BY

PATIENT NAME_____

PHYSICAL ADDRESS_____

PATIENT IS ____ A MINOR ___ OVER 65 YEARS OF AGE ____OTHER

REQUIRES ELECTRICTY TO OPERATE __ YES __ NO NEED FOR EQUIPMENT ___ Short Term ___ Long Term

DOES DEVICE HAVE AN EMERGENCY POWER SUPPLY?_____

PHYSICIANS SIGNATURE_____

PHYSICIANS NAME (PRINTED)_____

PHYSICIANS MAILING ADDRESS_____

PHYSICIANS CONTACT NUMBER_____

CUSTOMER STATEMENT

I AGREE THAT THE INFORMATION PROVIDED IS ACCURATE. I UNDERSTAND THAT THIS INFORMATION MUST BE VERIFIED AND PROVIDED TO THE POWER COMPANY EACH YEAR. WHEN THE EQUIPMENT IS NO LONGER NEEDED, I WILL NOTIFY THE POWER COMPANY TO UPDATE MY ACCOUNT AND DISCONTINUE REQUEST FOR ANNUAL VERIFICATION.

I UNDERSTAND THAT THE POWER COMPANY CANNOT GUARANTEE ELECTRIC SERVICE AND IT IS MY RESPONSIBILITY TO MAINTAIN A BACK-UP SYSTEM OR HAVE AN ALTERNATE PLAN IN THE EVENT OF POWER LOSS. FURTHERMORE, I UNDERSTAND THAT SERVICES MAY STILL BE REMOVED SHOULD I FAIL TO PAY THE MONTHLY BILL, REGARDLESS OF FILING THIS FORM.

CONSUMER SIGNATURE_____DATE_____

LREC LIFE SUPPORT FORM

PRINT OR TYPE

NAME OF CONSUMER _____

LREC ACCOUNT NUMBER_____

ADDRESS_____

CITY_____STATE_____ ZIPCODE_____

PHONE_____ CELL PHONE _____

PLACE OF EMPLOYEMENT_____

NAME OF PATIENT_____

RELATIONSHIP TO CONSUMER_____

HEALTH VERIFICATION MUST BE FILLED OUT BY PHYSICIAN OR STAFF ONLY

NATURE OF MEDICAL PROBLEM_____

_____

TYPE OF MEDICAL EQUIPMENT_____

WHEN IN USE: OCCASIONALLY _____ 4X DAILY _____ 24 HRS _____ OTHER _____

CAN THE PATIENT BE MOVED?_____

SPECIFY THE EFFECT SERVICE DISCONTINUANCE WILL HAVE UPON THE HEALTH OF THE IMPAIRED INDIVIDUAL_____

_____

DO THEY HAVE BACKUP AVAILABLE?_____

IS THE SITUATION CONSIDERED LIFE-THREATENING WITHOUT ELECTRIC SERVICE?

____YES ____NO

WHAT IS THE ESTIMATED DURATION OF THE LIFE THREATENING CONDITION?_____

_____

VERIFIER INFORMATION

NAME_____

TITLE & AGENCY (IF APPLICABLE)_____

ADDRESS_____

CITY _____ STATE _____ ZIP_____

SIGNATURE OF VERIFIER_____ DATE _____