APPLICATION FOR MEDICAL RESIDENTIAL ELECTRICAL SERVICE DISCOUNT PROGRAM

Customer to complete the following (please print):

Name _____ _____ - _____
As It Appears On Your Bill Account Number

Patient's Name: _____
(if different)

Service Address: _____
Street City Zip

Mailing Address: _____
(if different) Street City Zip

Home Phone ( ) _____ Work Phone ( ) _____

I heat my home mainly with { } gas { } electricity

I air-condition my home mainly with { } gas { } electricity

I certify that the above information is correct. I agree to let Island Energy enter my home during reasonable hours to verify this information. I understand that if I refuse to let Island Energy verify this information, I will lose my Medical Residential Electrical Service Discount.

I understand that this declaration is valid for one year starting the date shown below. Island Energy may review the declaration after a year to either (1) allow it to remain in effect beyond that one-year period; or (2) notify me that I must fill out a new declaration. Qualified applicants agree to follow Island Energy's Tariff and all conditions of the rate schedule.

Customer Signature _____ Date _____

Please notify Island Energy immediately if the person qualifying for the Medical Residential Electrical Service moves to another address or you no longer need the additional allowance.

440 Walnut Avenue - Mare Island, CA 94592
707-562-5000 - 707-562-5002 Fax
www.islandenergy.com

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THIS SECTION TO BE COMPLETED BY A LICENSED PHYSICIAN OR A PERSON LICENSED PURSUANT TO THE OSTEOPATHIC INITIATIVE ACT.

I certify that the medical condition and needs of _____, who is a full time resident of the customer household.

1 Requires use of a life-support device Yes ___ No _____

(A life support device is any medical device used to sustain life or relied upon for mobility. To qualify for a Residential Electric Service Discount this device must be used in the home and must run on gas or electricity supplied by Island Energy. The term "life support" includes, but is not limited to, respirators, iron lungs, hemodialysis machines, suction machines, electric nerve stimulators, pressure pads and pumps, aerosol tents, electrostatic and ultrasonic nebulizers, compressors, IPPB machines, and motorized wheelchairs. Devices used for therapy rather than for life support generally do not qualify.)

2 The following life-support device(s) is/are used in the above named patient's home (please indicate whether electricity is used to operate the device(s):

_____ [ ] electricity

_____ [ ] electricity

_____ [ ] electricity

3 Requires extra heating and/or cooling for one of the following:

Paraplegic	Yes _____	No _____
Quadriplegic	Yes _____	No _____
Hemiplegic	Yes _____	No _____
Multiple Sclerosis	Yes _____	No _____
Scleroderma (heating only	Yes _____	No _____

Other (please explain)

_____

_____

If you answered yes to question 3 above, is the special need for heating or air-conditioning medically necessary to sustain the life of the person or prevent deterioration of the person's medical condition?

Yes _____ No _____ (one of these two boxes must be checked)

4 Is being treated for a compromised immune system or life threatening illness.

Yes _____ No _____

Doctor's Name _____ Phone No. ( ) _____
Please Print

Office Address _____
Street City Zip

MD / DO California State License Number _____

Doctor's Signature _____ Date _____

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