Application for Medical Emergency Certification

CDE Lightband Use Only	Date	Name
Application Received		
Exemption Approved		

Please Print

Account No. _____ Billing Address _____

Customer Name _____ Service Address _____ Phone No. _____

Patient Name _____ Phone No. _____

Customer

I hereby attest that I am responsible for payment of the CDE Lightband billing of utility services at the service address shown on this application, and that this application for medical emergency certification is valid and not an attempt to delay or avoid just payment for services provided. I hereby agree to pay all billings promptly and acknowledge that this application, if approved, does not preclude CDE Lightband's right to partially limit utility services at the service address to pursue legal collection activities necessary for the recovery of unpaid billings, or to disconnect service under CDE Lightband's policies. CDE Lightband will disconnect service after providing notice via email provided below in advance of disconnection for nonpayment in accordance with CDE Lightband policies.

Customer Signature _____ Date _____

Customer Email _____

Patient

I hereby attest that I am a full-time, permanent resident at the CDE Lightband service address shown on this application and that my medical condition is such that the complete termination of CDE Lightband electric service would seriously endanger my health. In consideration of CDE Lightband's approval of this application, I acknowledge CDE Lightband's right to limit delivery of CDE Lightband services to this service address during any and all periods of nonpayment, up to and including complete disconnection of service after providing advance notice in accordance with CDE Lightband policies. I agree to hold CDE Lightband harmless form any damages relating to any complete termination that may occur incidentally as a result of a system failure, or due to nonpayment by the CDE Lightband customer listed on this application. In the event termination does occur, I agree to promptly notify and cooperate with CDE Lightband so service may be restored as soon as possible. I release CDE Lightband from all liability, claims, damages of property, injury or death, or expenses that may result from any complete termination which may occur incidentally as a result of system failure or due to nonpayment.

Patient Signature _____ Date _____

Medical Authorization

I hereby attest that I am a ☐ licensed physician / ☐ professionally certified health services official, that I have personally examined the above Patient, and that I have confirmed that complete termination of CDE Lightband electric service would seriously endanger the patient's health.

☐ **This patient suffers form a hazardous medical condition and termination of electric service would be especially dangerous or life-threatening.**

☐ **This patient uses life-supporting equipment and termination of electric service would make operation of this equipment impossible or impractical.**

I have advised my patient that disclosure of the requested information may be subject to redisclosure by the recipient and no longer protected by HIPAA rules & regulations.

Medical Authority Signature _____ Business Address _____ Phone No. _____

Print Name _____ Title _____ Date _____

This certification will expire 1 year from date of approval. It is the responsibility of the customer / patient to renew this certification if conditions extend beyond 1 year.

Mail:
CDE Lightband Operations Dept.
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Clarksville, TN 37040

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