

LIFE SUPPORT ALERT PROGRAM REGISTRATION FORM



CUSTOMER SERVICE
 1200 East First Avenue
 Anchorage
 Alaska
 99501-1685

phone
 907.263.5340
 credit office
 907.263.9200
 fax
 907.277.9272

Please Type or Print

Customer's Name _____

Telephone Number _____

Address (Location of life support equipment) _____

City, State, Zip _____

Patient's Name _____

Telephone Number _____

Relationship to Customer _____

Reason for life support _____

Type of life support equipment (include manufacturer & model number) _____

Frequency of use: Continuous _____ Intermittent _____ (If so, how often?) _____

Back-up power system _____

Name of treating physician _____

Physician's Address _____
 _____ City State Zip

Telephone Number _____

SPECIAL NOTE: ML&P CANNOT GUARANTEE UNINTERRUPTED SERVICE. CUSTOMERS WITH LIFE SUPPORT EQUIPMENT SHOULD HAVE STAND-BY POWER SOURCES. WE ALSO REQUEST THAT, IF POSSIBLE, THE CUSTOMER IMMEDIATELY NOTIFY US BY TELEPHONE IN THE EVENT OF A POWER OUTAGE.

Patient is asked to obtain doctor's or licensed Health Care Provider's signature at next appointment and return completed form to:

LIFE SUPPORT ALERT PROGRAM
 Municipal Light & Power
 1200 E 1st Avenue
 Anchorage, AK 99501
 263-5340

PHYSICIAN OR LICENSED HEALTH CARE PROVIDER VERIFICATION

I certify that _____ is being treated by me for the condition described and that the equipment noted above is used by the patient for treatment of this condition.

 Physician's signature

 Date