



Medical Needs Notification
Electrically Operated Medical Equipment

Dominion North Carolina Power

The purpose of this form is to identify Dominion North Carolina Power (Dominion) customers who have a medical condition and who depend upon electrically operated medical equipment as part of their continuing treatment.

To Be Completed By Customer			
Instructions: Please enter requested information; then forward this form to your physician.			
Customer Name		Dominion Account Number	
Customer Street Address		Daytime Telephone Number ()	Evening Telephone Number ()
City	State	Zip Code	Customer's Relationship to Patient (Check one) <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other (Specify): _____
Patient Name		Patient Age	
I hereby authorize my physician to release the following information about the above-named patient to Dominion Customer Service and to answer related questions to help in determining the patient's medical need for electricity. I certify that the patient resides at the address listed above.			
Patient Signature (Parent or guardian, if patient is under 18 or mentally incapacitated)			Date

To Be Completed By Physician			
Instructions: Please complete and return this form within 10 working days to Dominion at the address listed below. We will then place a note on our records to reflect that there is a medical need for electricity.			
Physician Name		Telephone No. (Incl. area code) ()	Fax No. (Include area code) ()
Hospital or Medical Group Affiliation			
Physician Office Address		City	State Zip Code
Patient's Diagnosis			
I have prescribed the following electrically powered medical equipment for this patient. (Please check as applicable.)			
<input type="checkbox"/> Mechanical ventilator	<input type="checkbox"/> Home dialysis machine		
<input type="checkbox"/> Other respiratory device (Specify): _____	<input type="checkbox"/> Infant apnea monitor		
<input type="checkbox"/> IV pump or feeding pump	<input type="checkbox"/> Other (Specify): _____		
<input type="checkbox"/> Continuous oxygen	_____		
Length of Time This Equipment Is Required By Patient			
Comments			
To the extent of my knowledge, the preceding information is correct.			
Physician Signature			Date

Physician: please mail completed form to: Dominion Credit Services, P.O. Box 26666, Richmond, VA 23261
OR Fax to: 1-888-867-3133.

If you have questions about this form, please call: 1-888-667-3000.